

Holistic Health Assessment in Nursing Practice I.

Holistic Health Assessment in Nursing Practice I.

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Author's Preface

Introduction

Holistic Health Assessment in Nursing Practice I supports nursing students as they develop the foundational knowledge, communication skills, and clinical judgement needed to provide safe, ethical, and person-centred care. Rather than approaching assessment as a series of tasks, the book encourages learners to consider the whole person, including the physical, emotional, social, cultural, developmental, and contextual factors that influence health.

The book begins with the therapeutic nurse-client relationship and examines cultural humility, trauma-informed care, strengths-based nursing, and therapeutic communication. Learners are then introduced to professional, ethical, and legal responsibilities; privacy, confidentiality, and boundaries; nursing theory and patterns of knowing; the nursing process; critical thinking; and clinical judgement. Later chapters guide learners through health history interviewing, subjective and objective data collection, documentation and reporting, complex communication situations, assessment and communication of vital signs, and infection prevention and control.

Designed with beginning nursing students in mind, this open educational resource includes learning objectives, practical examples, case studies, videos, interactive activities, reflection exercises, chapter summaries, and useful assessment checklists. Together, these features help learners build confidence, apply concepts to nursing situations, and develop a thoughtful and holistic approach to patient assessment.

A Note About “Patient” vs. “Client” Terminology

In nursing, the terms “patient” and “client” are both used to describe the person receiving care. The word “patient” is commonly used in many clinical and health-care settings and often refers to a person receiving assessment, treatment, or support from a health-care provider. The word “client” is also widely used in nursing and may reflect a broader view of care that includes individuals, families, groups, communities, or populations. It can also emphasize partnership, autonomy, and the person’s active role in their own health and care.¹

Throughout this book, the term “patient” is used most often to support consistency and clarity for learners. However, readers may occasionally encounter the term “client,” particularly when discussing the therapeutic nurse-client relationship, professional standards, or adapted open educational resources that use this terminology. In these cases, “patient” and “client” should be understood as related terms that both refer to the person, family, group, or community receiving nursing care. The use of one term over the other does not change the nurse’s responsibility to provide safe, respectful, ethical, culturally responsive, and person-centred care that follows professional, ethical, legal, and organizational responsibilities of an RN.

1. **Note:** CNO defines “client” broadly to include individuals, families, groups, communities, or populations receiving nursing care, while noting that “patient” may be used in some legal contexts and clinical settings (CNO, 2026).

About Our Nursing Program

Fanshawe's four-year *Honours Bachelor of Science in Nursing* (BScN) blends hands-on clinical education, academic excellence, and cutting-edge clinical simulation facilities to prepare students for a rewarding nursing career. Students learn in small, interactive classes with expert faculty, gain real-world experience in diverse health settings, and build meaningful community connections. With strong personalized support services, innovative equipment and a close-knit campus, students will graduate with the knowledge, skills, confidence, and competitive edge to make a meaningful impact in people's lives.

The Use of “Nurse” in the Book

Fanshawe College's Honours Bachelor of Science in Nursing (BScN) program educates students to help them become Registered Nurses (RNs). The book addresses the scope of practice, professional, ethical, and legal responsibilities of nurses registered to practice as RNs in Canada and, more specifically, in Ontario. While the theory is applicable to nursing anywhere in the world, given that nursing is a self-regulated profession, the reader is reminded to check any potential differences in professional, ethical, and legal responsibilities of RNs working outside of Ontario and Canada.

Chapter 8 Videos Nursing Students Contributors

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Lorena M. Bonilla, RN, BA, BSN, MN, EdD

Professor, Fanshawe College

Book Overview

Introduction

This Open Educational Resource (OER) is designed to support students in *NRSG 7133: Holistic Assessment: Theory*, which enables learners to understand the therapeutic nurse-client relationship and relational practice as the basis for nursing. Focusing on communication skills, students engage in learning opportunities to enhance therapeutic communication, interviewing, and relational practices with clients across the lifespan. Learners document client care in accordance with standards of practice.

This resource includes learning supports such as review and reflection prompts, case study analysis and videos, and opportunities to practice applying concepts through interactive examples, activities, and theory-to-practice exercises.

Chapter Overview

Below is a high-level overview of the topics and themes discussed in this book:

Chapter 1

The Therapeutic Nurse-Client Relationship and Therapeutic Communication

Chapter 1 introduces the therapeutic nurse-client relationship as the foundation of holistic nursing care. The reader will explore the core components of this relationship and examine how cultural humility, trauma-informed care, and strengths-based approaches support safe, respectful, and person-centred practice. The chapter also introduces therapeutic communication in nursing, including strategies for communicating with patients and key communication concepts that help nurses build trust, understand patient experiences, and support meaningful health assessment.

[Jump to Chapter 1](#)

Chapter 2

Professional, Ethical, and Legal Nursing Responsibilities — Privacy & Confidentiality

Chapter 2 introduces the professional, ethical, and legal responsibilities that guide nursing practice, with a focus on privacy and confidentiality. The reader will explore expectations for professional nursing conduct, ethical decision-making, and legal accountability in the context of holistic health assessment. The chapter also examines the importance of protecting patient information, maintaining appropriate boundaries, and practising in ways that promote trust, safety, respect, and accountability within the nurse-client relationship.

[Jump to Chapter 2](#)

Chapter 3

Knowledge, Critical Thinking, and Holistic Health Assessment

Chapter 3 explores the knowledge, thinking processes, and theoretical foundations that guide holistic health assessment in nursing practice. The reader will examine the role of nursing theory, personal philosophy, and patterns of knowing in shaping professional practice. The chapter also introduces the nursing process, critical thinking, and clinical judgment as essential tools for thinking like a nurse and making informed decisions. In addition, the chapter considers how holistic assessment supports a comprehensive understanding of the patient's physical, emotional, social, cultural, and contextual health needs.

[Jump to Chapter 3](#)

Chapter 4

Health History, Data Collection, Documentation, and Reporting

Chapter 4 introduces the health history interview as a structured process for gathering meaningful information during a holistic health assessment. The reader will explore each phase of the interview, including pre-orientation, orientation, working, and termination, as well as key areas to address during subjective data collection. The chapter also distinguishes between subjective and objective data, introduces nursing interventions, and examines the importance of accurate documentation and reporting in supporting safe, ethical, and effective nursing care.

[Jump to Chapter 4](#)

Chapter 5

Complex Communication in Nursing Practice

Chapter 5 focuses on complex communication in nursing practice and the strategies nurses use to communicate effectively in diverse and challenging situations. The reader will explore developmental considerations, language barriers, auditory and visual challenges, cognitive challenges, and emotionally difficult conversations. The chapter also examines communication in situations involving patient and family conflict, as well as conflict with colleagues, emphasizing the importance of respect, clarity, empathy, and professionalism in supporting safe and therapeutic nursing care.

[Jump to Chapter 5](#)

Chapter 6

Assessment and Communication of Vital Signs

Chapter 6 introduces the assessment and communication of vital signs as essential components of holistic nursing practice. The reader will explore general considerations for obtaining accurate measurements and assessing pulse, respirations, oxygen saturation, blood pressure, and temperature. The chapter also emphasizes the interpretation and communication of findings, recognition of factors that may influence vital signs, and the use of critical thinking and reflection to support safe, timely, and person-centred nursing care.

[Jump to Chapter 6](#)

Chapter 7

Infection Prevention and Control

Chapter 7 introduces the principles and practices of infection prevention and control in nursing care. The reader will explore strategies for preventing infection, including standard precautions, additional transmission-based precautions, and the appropriate selection and use of personal protective equipment. The chapter also examines essential infection-control practices, hygienic patient-care interventions, surgical asepsis, and the principles of sterile technique, emphasizing their role in protecting patients, nurses, and others in health-care settings.

[Jump to Chapter 7](#)

Chapter 8

Theory to Practice – Simulation-Based Learning

Chapter 8 provides opportunities to apply concepts from throughout the book through simulation-based case scenarios reflecting a variety of nursing situations. The reader will practise

establishing therapeutic nurse-client relationships, conducting holistic health interviews, collecting subjective and objective data, assessing patient needs, and applying critical thinking and clinical judgement.

Jump to Chapter 8

Appendices

This book also contains the following *Appendices* to complement the chapter content:

- Appendix A: Subjective Health Assessment Categories
 - A.1 Introductory Information: Demographic and Biographic Data
 - A.2 Main Health Needs (Reasons for Seeking Care)
 - A.3 Current and Past Health
 - A.4 Mental Health and Mental Illnesses
 - A.5 Functional Health
 - A.6 Preventive Treatments and Examinations
 - A.7 Family Health
 - A.8 Cultural Health
 - A.9 Developmental Considerations
- Appendix B: Health History References
 - B.1 Components of the General Survey (ASEPTIC)
 - B.2 Components of a Nursing Health History
 - B.3 Steps for Conducting a Health History Interview
- Appendix C: Complex Communication
 - C1: Impaired Hearing and Vision Strategies
 - C2: Strategies for Clients with Impaired Speech
- Appendix D: Vital Signs
 - D1: Vital Signs Checklist I
 - D2: Vital Signs Checklist II
 - D3: Checklist for Blood Pressure

CHAPTER 1: THE THERAPEUTIC NURSE-CLIENT RELATIONSHIP (TNCR) AND THERAPEUTIC COMMUNICATION

Chapter Overview



- 1.0 Learning Objectives
- 1.1 Chapter Introduction
- 1.2 Core Components of the Therapeutic Nurse-Client (TNCR) Relationship
- 1.3 Cultural Humility
- 1.4 Trauma-Informed Approach to Nursing Care
- 1.5 Strengths-Based Nursing Care
- 1.6 Therapeutic Communication in Nursing Practice
- 1.7 Communicating With Patients
- 1.8 Basic Communication Concepts
- 1.9 Chapter Summary

1.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Explain the importance of establishing therapeutic nurse-client relationships as the foundation for providing nursing care.
2. Identify the core components for establishing therapeutic nurse-client relationships.
3. Apply the gained knowledge and skills for establishing therapeutic nurse-client relationships.
4. Demonstrate how to effectively establish therapeutic nurse-client relationships while integrating cultural humility, trauma-informed care, and strength-based nursing approaches to care.
5. Reflect on the gained knowledge as well as the practice and skills needed to improve establishing effective therapeutic nurse-client relationships in any context of care.

1.1 Chapter Introduction

The therapeutic nurse-client relationship (TNCR) is the essence of nursing practice. It is the vehicle through which nurses attempt to meet patient needs in a safe, competent, ethical, caring, and compassionate manner. Each person knows what it is like to be them and has the potential for growth and healing (Carl Rogers as cited in Yao & Kabir, 2023). According to Parse, individuals are experts at being themselves. Therefore, they create meaning about their lives, and the nurse's role is to help them navigate and find their own way (Parse, 1992).

Nurses bring their values, beliefs, biases, culture and everything that makes them who they are to their professional nursing role. Consider how you will hold physical and emotional space for your patients regardless of what you might think and feel about them. What will you do to make people feel seen, heard, valued, and accepted? How will you make your patients feel safe (physically, spiritually, and culturally) when they are with you? What might you do if you do not feel safe with a patient? What might you do if you do not like your patient or agree with their life choices?



What would you do and say as the nurse?

The nurse visits a 3-week-old baby and their mom at home. The baby is fuzzy and drooling a lot. The nurse notices white spots on the tongue. Mom tells the nurse that “the baby’s bum is bright red again, although I try to change the diaper every time it is dirty”. Mom looks tired and dishevelled. She fidgets and moves a lot when she is not kissing the baby’s head or rocking their little body. Mom’s clothes look dirty, and the shirt has wet spots at the breast. She often presses her breasts and winces in discomfort.

1.2 Core Components of the Therapeutic Nurse-Client (TNCR) Relationship

The College of Nurses of Ontario (CNO) states that trust, respect, professional intimacy, empathy, and power ensure the nurse provides safe and compassionate care (CNO, 2025a).

1.2.1 Trust

Trust is essential in the TNCR. It must be established as soon as the nurse meets the patient to build a professional relationship. Without trust, the nurse cannot accurately assess the patient's needs, understand the lived experience, address potential needs, or implement and evaluate the plan of care.



Video: Building Trust with Patients

Video: "Building Trust with Patients: 5 Keys to Better Healthcare Outcomes!" by nurselyf [4:32] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

1.2.2 Respect

In nursing care, respect is the intentional act of upholding patients' dignity, autonomy, and worth, thereby strengthening the TNCR and improving health outcomes. Nurses must recognize that patients are unique and autonomous. Professionally and ethically, nurses must accept all patients regardless of age, race, ethnicity, language, socioeconomic status, nationality, educational background, health or illness, values and beliefs, among other individual characteristics.



Watch: When You Look at Me

Video: "When You Look at Me" by Citizen [2:30] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Patients must also show respect to nurses. Mutual respect is necessary for the nurse to provide safe, ethical, competent, caring, and compassionate care to patients.



Watch: Compassion, Dignity and Respect in Health Care

Video: “Compassion, dignity and respect in health care” by The Health Foundation [4:16] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

1.2.3 Professional Intimacy

Professional intimacy in nursing is the essential, therapeutic closeness—physical, psychological, or spiritual—developed between nurse and patient to foster trust, safety, and optimal care. It involves managing intimate, often unavoidable, physical care and emotional vulnerability while maintaining strict professional boundaries (Antonytheva et al., 2021).



Watch: It’s a Nurse

Video: “It’s a Nurse” by Health First [7:14] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

1.2.4 Empathy

Nurses must understand what is important to the client, based on their life context, to provide safe, competent, and ethical nursing care. They must be able to appreciate the client’s lived experience, perspective, and emotions without becoming emotionally too consumed. Provided that the nurse follows professional, ethical, and legal responsibilities while attempting to meet the client’s needs, nurses do not need to agree with the client’s life choices. Empathy is multidimensional and includes cognitive (perspective taking), affective (feeling with), and behavioural (action) components.



Watch: On Empathy

The Three Components of Empathy

Video: “The Three Components of Empathy” by bhasin consulting inc. [1:29] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Brené Brown on Empathy vs Sympathy

Video: “Brené Brown on Empathy vs Sympathy” by Diana Simon Psihoterapeut [2:54] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Sympathy, Empathy, and Compassion: How do they differ, and which one do people prefer?

Video: “Sympathy, Empathy, and Compassion: How do they differ and which one do people prefer?” by Compassion Research Lab [3:38] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Empathy: The Human Connection to Patient Care

Video: “Empathy: The Human Connection to Patient Care” by Cleveland Clinic [4:24] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

1.2.5 Power

Power is a multifaceted concept that involves the ability to influence, advocate, and bring about change. There are different sources of power. A nurse’s power derives from expert knowledge, professional authority, and the therapeutic nurse-client relationship. Nurses can empower patients and improve their care outcomes. The effective use of power can improve a patient’s overall quality of care. A nurse’s lack of power can hinder their ability to advocate and professional growth.



Watch: The Difference between Care and Caring

Video: “The Difference Between Care & Caring” by Royal Alexandra Hospital Foundation [3:04] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activities: Therapeutic Relationships

For additional resources and exercises related to therapeutic relationships, please see section five of *Therapeutic Relationships: Teaching activities and resources* from RNAO (Registered Nurses' Association of Ontario)

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1.3 Cultural Humility

Using a client (or patient)-centred care approach to care, nurses recognize the uniqueness of their patients. Therefore, they practice in ways that honour, respect, and acknowledge individual values, beliefs, and cultural traditions (College of Nurses of Ontario [CNO], 2025).

Link to Learning

Two community health nurses share their practical advice on how to combat anti-Indigenous racism:

- Positive disruption: Sharing reflections, championing change, and inspiring action



Watch: CNA Review: Person-Centered Care

Video: “CNA Review: Person-Centered Care” by WisTech Open | Open RN [1:18] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Watch: On Humility

Cultural Humility in Action: Nurturing Inclusion in Long-Term Care

Video: “Cultural Humility in Action: Nurturing Inclusion in Long-Term Care” by Ontario CLRI [5:32] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Peer Insights | Cultural Humility Case Studies and Practical Applications

Video: “Peer Insights | Cultural Humility Case Studies and Practical Applications” by Patient Empowerment Network [5:42] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

The nurse notices that the patient is not losing weight or exercising as directed in the plan of care. The doctor is not happy with the patient's "lack of compliance" and tells the patient they cannot do much for them unless they "take things seriously by taking all their meds, losing weight, eating healthy and getting some exercise". The patient looks very ashamed and tells the nurse, "I don't know what to do.... I really want to lose weight and exercise, so I don't get sick. My family really needs me. I have to work to help my parents. I also have to support my partner and my kids".

I *What would you say and do? How might you apply the core components of the TNCR and cultural humility?*

1.4 Trauma-Informed Approach to Nursing Care

Trauma-informed care (TIC) recognizes the widespread impact of trauma; therefore, nurses seek to actively resist re-traumatization by focusing on safety, trust, and empowerment of clients. It shifts the focus from “What’s wrong with you?” to “What happened to you?” Key nursing actions include establishing physical/emotional safety, providing clear communication, offering choice, and fostering collaborative care (Fleishman et al., 2019).

Link to Learning

- Trauma-Informed Care (from the *American Association of Colleges of Nursing*)
‘Hurt people can hurt people’: why it’s important to adopt a trauma-informed approach to nurses’
- well-being
(from the *Canadian Nurses Association*)



Watch: Strengths-Based and Trauma-Informed Practice

Video: “Strengths-based and Trauma-informed Practice (Looking beneath the surface)” by College of Physicians and Surgeons of British Columbia [3:45] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activities: Trauma-Informed Care

For additional resources and exercises related to therapeutic relationships, please see section five of *Trauma-Informed Care: Teaching activities and resources* from RNAO (Registered Nurses’ Association of Ontario)

From Theory to Practice

During clinical, you are assigned to provide care to a 16-year-old patient scheduled to have surgery. The patient confides in you by sharing that they are worried about their parents. The patient has two younger siblings, and all three were born in Canada. Their parents came to Canada from another country and do not speak English well. Although the parents went to university in their country, your patient usually translates and “helps them out with important stuff”.

 *What would you say and do? How might you apply the core components of the TNCR and cultural humility while practicing from a trauma-informed perspective?*

1.5 Strengths-Based Nursing Care

Strengths-based nursing care is a philosophy and approach that focuses on identifying, mobilizing, capitalizing, and developing a patient's strengths to manage health challenges, facilitate healing, and foster empowerment.

Link to Learning

- Strengths-Based Nursing and Healthcare (from Ingram School of Nursing – McGill)
- Strengths-Based Nursing and Healthcare (SBNH). SBNH shifts the focus from a deficit-based, problem-focused model to a person-centred, relational approach that empowers patients to manage their own care, as explained by Laurie N. Gottlieb, RN, PhD, ScD (hon), Fellow of the Canadian Academy of Health Sciences (FCAHS).



Watch: Strengths-Based Nursing Reflection

Video: "Strengths-Based Nursing Reflection (2021), directed by Kitra Cahana" by Strengths-Based Nursing and Healthcare [4:28] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

The nurse visits a new client who has been added to their community roster. The client was referred by the High School after being recently diagnosed with Diabetes. The nurse is told that MK is 16, plays soccer, and has a very supportive father and grandmother.

What would you say and do? How might you apply the core components of the TNCR and cultural humility while practicing from a trauma-informed and SBNH perspective?

1.6 Therapeutic Communication in Nursing Practice

To establish a TNCR, the nurse moves through the preinteraction, orientation, working, and termination phases. The nurse needs to assess the patient to understand their life experience using effective verbal and non-verbal communication. Ideally, the nurse will communicate therapeutically to be able to build rapport, foster a safe environment, and provide holistic patient-centred care. Through effective communication, the nurse can learn the patient's story to understand their challenges, values, beliefs, goals, impact of illnesses, and coping patterns, among other things. Therapeutic communication techniques are the tools that nurses use to discover a patient's life as is, as perceived, and as lived (Parse, 1992).

Overview of Communication

When you think of communication, talking to another person or texting them might come to mind first. However, while talking and texting are methods of communication, they do not represent a comprehensive definition of communication.

A more comprehensive understanding of communication refers to the sharing of information, ideas, and feelings, typically aimed at mutual understanding. In this way, you must consider the sender, the recipient, and the transaction. Simply put, the sender is the person sharing the message, the recipient is the person receiving and interpreting it, and the transaction is the way the message is delivered and the factors that influence the communication's context and environment. As you can see, communication is a complex process. It involves more than just what you say and takes many forms, as reflected in Figure 1.6.1.



Figure 1.6.1: Forms of communication. Image: "Three hands, parents and child," by LatticeC, Wikimedia Commons, CC0 1.0.

There are three types of communication:

Verbal communication

Verbal communication is oral communication that happens through spoken words, sounds, vocal intonation, and pace. It can occur face-to-face, one-on-one, or in groups, over the telephone, or via video conferencing. As a nurse, you will engage in verbal communication with clients, families, colleagues, and interprofessional teams.

Non-verbal communication

Non-verbal communication is a type of communication that occurs through facial expressions, eye contact, gestures, and body positions and movements. As a nurse, you will learn that your non-verbal communication is important because it can both reinforce or contradict what you say verbally. Additionally, non-verbal communication is used more often than verbal communication.

Thus, you must become aware of your non-verbal communication.

- **Written communication**

- Written communication is a type of communication that occurs through written words, symbols, pic-

tures, and diagrams. You are probably familiar with some informal, written types of communication, such as texting or emailing someone, posting a picture on Instagram, or using an emoji on X. You may also have engaged in more scholarly forms of written communication, such as letters and papers. As a nurse, written communication also involves documentation, such as notes, and scholarly writing, including essays, peer-reviewed publications, protocols, practice standards, and best-practice guidelines. You may not be familiar with some of these types of written communication yet, but you will become more acquainted with them over the course of your nursing program.



Activity: Check Your Understanding

Text Description

Which are considered examples of non-verbal communication? **Select all that apply.**

- a. Eye contact while speaking.
- b. Emotions reflected on a nurse's face.
- c. The speed of a nurse's voice when talking to a client.
- d. Scholarly writing in a paper.
- e. Emailing a question to a professor.

Solution:

Correct answer(s): a. Eye contact while speaking;; b. Emotions reflected on a nurse's face;;



Watch: Verbal V.s Non-verbal Communication

Video: “

VERBAL VS NON-VERBAL Communication | Therapeutic Communication |Lecturio Nursing Fundamentals/Theory

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1.7 Communicating With Patients

The Nurse-Client Relationship

The nurse-client relationship, also called a helping relationship, is crucial for holistic, compassionate nursing care. During a nurse-client relationship, the nurse builds rapport and establishes trust with the purpose of actively engaging the client in discussions about their feelings, emotions, care process, and decision-making. Establishing rapport with clients is of the utmost importance because it facilitates an open and honest dialogue between the client and the nurse. It facilitates therapeutic communication and engages the client in decision-making regarding their plan of care. The nurse-client relationship is a professional relationship in which the nurse practices the “art of nursing,” an abstract connection between the client’s needs, expressed behaviours, and the nurse’s perceptions and exploration of these concepts (Ernstmeyer & Christman, 2022).

Phases of the Nurse-Client Relationship

The nurse-client relationship evolves through several phases. A well-known nurse theorist named Hildegard Peplau described these three phases as the orientation phase, working phase, and termination phase. Some sources include an additional phase called the pre-interaction phase (O’Brien, 2012; Ernstmeyer & Christman, 2022).

- **Preinteraction Phase:** The nurse reviews the medical record or other data in preparation for the orientation phase. The preinteraction phase can also be helpful in identifying preconceived notions about a client situation, acknowledging these feelings, and making a conscious effort to avoid biases.
- **Orientation Phase:** The orientation phase is a brief encounter where the nurse addresses the client by name and then introduces themselves to the client, including their name and role. This introduction should include an estimated time frame for the conversation or encounter, and an explanation of what will occur. The nurse should begin to establish trust and rapport by ensuring privacy. This is especially important if sensitive topics will be discussed. While obtaining information about the client, it is important to realize the client is a unique individual with distinct needs, priorities, values and belief systems, and should be treated as such. While the nurse may not agree with the client’s values and belief systems, the nurse must respect them. Failure to establish rapport and trust during the orientation phase will block communication and make it difficult for the nurse to fully engage in therapeutic communication with the client.
- **Working Phase:** After the orientation phase is complete, the working phase begins. The majority of a nurse’s time is spent in the working phase with a client. Communication during the working phase should be client-focused and based on what is important to the client. Communication generally focuses on their reason for seeking medical care, but deeper concerns are discussed and explored as they come up. During the working phase, the nurse engages in therapeutic communication by recognizing cues, such as body language or statements about emotions, and then encourages further discussion about the client’s feelings about a particular subject. The conversation should be focused on the client’s feelings and thought processes, not the nurse’s feelings and thoughts. If rapport and trust were successfully developed during the orientation phase, the client is more likely to engage in therapeutic communication with the nurse, who is perceived as an educator and counsellor, in addition to a health care professional. The nurse uses therapeutic communication techniques to help the client gain an awareness of their deeper feelings, existing coping mechanisms, and overall goals for care. The nurse should remain nonjudgmental while providing feedback and reflection regarding what the client is saying, both verbally and nonverbally. Therapeutic communication techniques, as well as common communication blocks, are discussed later in this chapter.

- **Termination Phase:** The termination phase is the last phase of the nurse-client relationship and occurs at the end of a communication session. Termination generally occurs when the goals of the therapeutic communication session have been met. Ideally, the nurse should inform the client that termination is approaching rather than abruptly ending the interaction. Abruptly ending the conversation can lead to negative feelings about the interaction and can be perceived as uncaring by the client. The nurse should review the goals of the interaction, achievements made during the interaction, and other sources of support available to the client. Termination should be a concrete occurrence, and as such, the nurse should avoid using terms such as “I’ll see you later” or “Keep in touch,” because these terms insinuate that termination is temporary.

Therapeutic Communication

Therapeutic communication is a type of professional communication used by nurses with clients. It is defined as “The purposeful, interpersonal information-transmitting process through words and behaviours based on both parties’ knowledge, attitudes, and skills, which leads to client understanding and participation.” (Abdolrahimi et al., 2017). Her therapeutic communication techniques used by nurses have roots going back to Florence Nightingale, who insisted on the importance of building trusting relationships with clients and believed in the therapeutic healing that resulted from nurses’ presence with clients (Karimi & Masoudi Alavi, 2015). Since then, several professional nursing associations have highlighted therapeutic communication as one of the most vital elements in nursing.



An Example

A Nursing Student Using Therapeutic Communication

Ms. Z. is a nursing student who enjoys interacting with clients. When she goes to clients’ rooms, she greets them and introduces herself and her role in a calm tone. She kindly asks clients about their problems and notices their reactions. She does her best to encourage problem-solving and answer questions. Clients perceive that she wants to help them. She treats clients professionally by respecting boundaries and listening to them in a nonjudgmental manner. She addresses communication barriers and respects clients’ cultural beliefs. She notices clients’ health literacy and ensures they understand her messages and client education. As a result, clients trust her and feel as if she cares about them, so they feel comfortable sharing their health care needs with her (Abdolrahimi et al., 2017).



“
Nurse taking care of senior patient in
wheelchair
” by agilemktg1, CCO 1.0.

Active Listening and Attending Behaviours

Listening is obviously an important part of communication. There are three main types of listening: competitive, passive, and active. Competitive listening happens when we are focused on sharing our own point of view instead of listening to someone else. Passive listening occurs when we are not interested in listening to the other person, and we assume we understand what the person is communicating correctly without verifying. During **active listening**, we are communicating verbally and nonverbally that we are interested in what the other person is saying while also actively verifying our understanding with the speaker. For example, an active listening technique is to restate what the person said and then verify our understanding is correct. This feedback process is the main difference between passive listening and active listening (Anonymous, 2024).

Touch

Therapeutic use of touch is a powerful way to professionally communicate caring and empathy if done respectfully while being aware of the client's cultural beliefs. Nurses commonly use professional touch when assessing, expressing concern, or comforting clients. For example, simply holding a client's hand during a painful procedure can be very effective in providing comfort. However, nurses must be aware that the therapeutic touch may not be appropriate in all situations. It is essential to respect personal boundaries and avoid touch if the client is not receptive. For example, cultural beliefs may view touch by a member of the opposite sex as inappropriate, or the client may have previously experienced trauma that causes touch to be uncomfortable or trigger negative emotions. See Figure 1.7.1 for an image of a nurse using touch as a therapeutic technique when caring for a client.



Figure 1.7.1: Using Touch as Therapeutic Communication. Image: "Official U.S. Navy Imagery – A nurse examines a newborn baby.jpg" by MC2 John O'Neill Herrera, Wikimedia Commons, CC0 1.0.

Therapeutic Techniques

Therapeutic communication techniques are specific methods used to provide clients with support and information while focusing on their concerns. These techniques encourage clients to explore their feelings, solve problems, and use coping responses for medical conditions and life events. Nurses assist clients to set goals and select strategies for their plan of care based on their needs, values, skills, and abilities. They recognize the autonomy of the clients to make their own decisions, maintain a nonjudgmental attitude, and avoid interrupting while communicating therapeutically. Depending on the developmental stage and educational needs of the client, appropriate terminology should be used to promote understanding and rapport. When using therapeutic communication, nurses often ask open-ended statements and questions, repeat information, or use silence to prompt clients to work through problems on their own. Table 1.7a describes a variety of therapeutic communication techniques (American Nurse, n.d.; Ernstmeyer & Christman, 2022).

Table 1.6.1. Therapeutic Communication Techniques

Therapeutic Technique	Description
Active Listening	By using nonverbal and verbal cues such as nodding and saying, "I see," nurses can encourage clients to continue talking. Active listening involves showing interest in what clients have to say, acknowledging that you're listening and understanding, and engaging with them throughout the conversation. Nurses can offer general leads such as "What happened next?" to guide the conversation or propel it forward.
Providing Silence	At times, it's useful not to speak at all. Deliberate silence can give both nurses and clients an opportunity to think through and process what comes next in the conversation. It may give clients the time and space they need to broach a new topic and allow quiet time for self-reflection. When providing silence, the nurse does not verbally respond after a client makes a statement, although they may nod or use other nonverbal communication to demonstrate active listening and validation of the client's message.
Acceptance	Sometimes it is important to acknowledge a client's message and affirm that they've been heard. Acceptance isn't necessarily the same thing as agreement; it can be enough to simply make eye contact and say, "Yes, I hear what you are saying." Clients who feel their nurses are listening to them and taking them seriously are more likely to be receptive to care.
Giving Recognition	Recognition acknowledges a client's behaviour and highlights it without giving an overt compliment. A compliment can sometimes be taken as condescending, especially concerning routine tasks. An example of a nurse giving recognition would be saying something such as, "I noticed you took all of your medications today." This statement draws attention to the positive action and encourages it.
Offering Self	Hospital stays can be lonely and stressful at times. When nurses are present with their clients, it shows clients they value them and are willing to give them time and attention. Offering to simply sit with clients for a few minutes is a powerful way to create a caring connection.
Giving Broad Openings/Open-Ended Questions	Therapeutic communication is often most effective when clients direct the flow of conversation and decide what to talk about. To that end, giving clients broad opening statements such as "Tell me about your concerns," can be a good way to allow clients an opportunity to discuss what's on their mind.
Seeking Clarification	Similar to active listening, asking clients for clarification when they say something confusing or ambiguous is important. Saying something such as "I'm not sure I understand. Can you explain it to me?" helps nurses ensure they understand what's actually being said and can help clients process their ideas more thoroughly.
Placing the Event in Time or Sequence	Asking questions about when certain events occurred in relation to other events can help clients (and nurses) get a clearer sense of the whole picture. It forces clients to think about the sequence of events and may prompt them to remember something they otherwise wouldn't.
Making/Sharing Observations	Observations about the appearance, demeanour, or behaviour of clients can help draw attention to areas that may indicate a problem. For example, stating an observation that a client looks tired may prompt them to explain why they haven't been getting much sleep lately, or making an observation that they haven't been eating much may lead to the discovery of a new symptom.

Encouraging Descriptions of Perception	For clients experiencing sensory issues or hallucinations, it can be helpful to ask about these perceptions in an encouraging, nonjudgmental way. If the client looks distracted or frightened as if they see or hear something, it is helpful for the nurse to use phrases such as “It looks like you may be hearing something. What do you hear now?” or “It looks as though you may be seeing something. What does it look like to you?” These phrases give clients a prompt to explain what they’re perceiving without casting their perceptions in a negative light. Nurses also establish safety by asking the client if the hallucinations are encouraging the client to harm themselves or others.
Encouraging Comparisons	Clients often draw upon previous experiences to deal with current problems. By encouraging them to make comparisons to situations they have coped with before, nurses can help clients discover solutions to their problems. For example, the following exchange demonstrates encouraging comparisons. Nurse: “It must have been difficult when you went through a divorce. How did you cope with that?” Client: “I walked my dog outside a lot.” Nurse: “It sounds like walking your dog outside helps you cope with stress and feel better?”
Summarizing	It is often useful to summarize what clients have said. This demonstrates to clients that the nurse was listening and allows the nurse to verify information. Ending a summary with a phrase such as “Does that sound correct?” gives clients explicit permission to make corrections if they’re necessary. For example, the following exchange demonstrates summarizing. Client: “I don’t like to take my medications because they make me feel tired and I gain a lot of weight.” Nurse: “You haven’t been taking your medications this month because of the side effects of fatigue and weight gain. Is that correct?”
Reflecting	Clients often ask nurses for advice about what they should do about particular problems. Nurses can ask clients what they think they should do, which encourages them to be accountable for their own actions and helps them come up with solutions themselves. For example, the following exchange demonstrates reflecting. Client: “Do you think I should do this new treatment or not?” Nurse: “What do you think are the pros and cons for the new treatment plan?”
Focusing	Sometimes during a conversation, clients mention something particularly important. When this happens, nurses can focus on their statement, prompting clients to discuss it further. Clients don’t always have an objective perspective on what is relevant to their case, but as impartial observers, nurses can more easily pick out the topics on which to focus. For example, the following exchange demonstrates focusing. Client: “I am nervous about going home.” Nurse: “You’re feeling anxious about going home. Tell me more about that.”
Confronting	Confronting presents reality, challenges a client’s assumptions, or points out inconsistencies with behaviours, feelings, or thoughts. Nurses should only apply this technique during the working phase after they have established trust. Confrontation, when used correctly, can help clients break destructive routines or understand the state of their current situation. For example, the following exchange demonstrates therapeutic confrontation with a client who has been admitted for alcohol withdrawal. Client: “I haven’t drunk much alcohol this year.” Nurse: “Yesterday you told me that every weekend you go out and drink so much that you don’t know where you are when you wake up.”
Voicing Doubt	Voicing doubt can be a gentler way to call attention to incorrect or delusional ideas and perceptions of clients. By expressing doubt, nurses can force clients to examine their assumptions.

Offering Hope	Because hospitals can be stressful places for clients, sharing hope that they can persevere through their current situation can help promote coping. However, nurses must avoid giving false reassurance. For example, telling a client who was recently diagnosed with a serious medical condition, “You’ll be fine,” is false reassurance and not therapeutic. On the other hand, stating, “I remember you shared with me how well you have coped with difficult situations in the past,” is an appropriate therapeutic use of offering hope.
Using Humor	Lightening the mood with humour can help nurses establish rapport and promote a positive state of mind. However, the client should not be given the impression that their situation is not serious or that the nurse is minimizing their feelings or concerns. Humour must be tailored to the client’s sense of humour, or clients may take offence.
Offering Empathy	Empathy is the ability to recognize, understand, and share feelings with another person. Empathy involves showing understanding of another’s situation or perspective and enables helping behaviours (Psychology Today Staff, n.d.).
Paraphrasing	Paraphrasing rephrases the client’s words and key ideas to clarify their message and encourage additional communication. For example, if a client states, “I’ve been way too busy today,” the nurse can therapeutically respond by stating, “Participating in physical and occupational therapy today has kept you busy.”
Presenting Reality	Presenting reality restructures the client’s distorted thoughts with valid information. For example, if a client who is hallucinating states, “I can’t go into that room, there are spiders on the walls,” the nurse can therapeutically respond, “I see no evidence of spiders on the walls.”
Restating	Restating uses different word choices for the same content stated by the client to encourage elaboration. For example, if a client states, “The nurses hate me here,” the nurse can respond therapeutically, “You feel as though the nurses dislike you?”

Communicating honestly, genuinely, and authentically is powerful. It opens the door to creating true connections with others. Communicating with empathy has also been described as providing “unconditional positive regard.” Research has demonstrated that when health care teams communicate with empathy, there is improved client healing, reduced symptoms of depression, and decreased medical errors (Morrison, 2019).

Nontherapeutic Responses

Nurses and nursing students must be aware of potential barriers to communication. In addition to considering common communication barriers discussed in the previous section, there are several **nontherapeutic responses** or communication blocks/barriers to avoid. These responses often block the client’s communication of their feelings or ideas. See Table 1.7b for a description of nontherapeutic responses (Ernstmeyer & Christman, 2022; Burke, 2026).

Table 1.7.2. Nontherapeutic Responses

Nontherapeutic Response	Description
Asking Personal Questions	Asking personal questions that are not relevant to the situation is not professional or appropriate. Don't ask questions just to satisfy your curiosity. For example, asking, "Why have you and Mary never married?" is not appropriate. A more therapeutic question would be, "How would you describe your relationship with Mary?"
Giving Personal Opinions	Giving personal opinions takes away the decision-making from the client. Effective problem-solving must be accomplished by the client and not the nurse. For example, stating, "If I were you, I'd put your father in a nursing home," is not therapeutic. Instead, it is more therapeutic to say, "Let's talk about what options are available to your father."
Changing the Subject	Changing the subject when someone is trying to communicate with you demonstrates a lack of empathy and blocks further communication. It implies you don't care about what they are sharing. For example, stating, "Let's not talk about your insurance problems; it's time for your walk now," is not therapeutic. A more therapeutic response would be, "After your walk, let's talk some more about what's going on with your insurance company."
Stating Generalizations and Stereotypes	Generalizations and stereotypes can threaten nurse-client relationships due to preconceived assumptions about clients that may or may not be true. For example, it is not therapeutic to state the stereotype, "Older adults are always confused." A more therapeutic response is to focus on the client's concern and ask, "Tell me more about your concerns about your father's confusion."
Providing False Reassurances	When a client is seriously ill or distressed, the nurse may be tempted to offer hope with statements such as "You'll be fine," or "Don't worry; everything will be alright." These comments tend to discourage further expressions of feelings by the client. Additionally, these comments may not present reality. If a client is terminally ill, telling them, "You'll be fine in no time," is not realistic and provides false reassurance. The client may perceive these statements as a minimization of their situation and associated feelings. A more therapeutic response would be, "It must be difficult not to know what the surgeon will find. What can I do to help?"
Showing Sympathy	Sympathy focuses on the nurse's feelings rather than the client's. Saying "I'm so sorry about your amputation; I can't imagine losing a leg." This statement shows pity rather than trying to help the client cope with the situation. A more therapeutic response would be, "The loss of your leg is a major change; how do you think this will affect your life?"
Asking "What" or "Why" Questions	A nurse may be tempted to ask the client to explain "why" they believe, feel, or act in a certain way. However, clients and family members may interpret "what" or "why" questions as accusations and become defensive. It is best to phrase a question by avoiding the words "what" or "why." For example, instead of asking, "Why are you so upset?" it is more therapeutic to rephrase the statement as, "You seem upset. Tell me more about how you are feeling."

Showing Approval or Disapproval	Nurses should not impose their own attitudes, values, beliefs, and moral standards on others while in the professional nursing role. Judgmental messages contain terms such as “should,” “shouldn’t,” “ought to,” “good,” “bad,” “right,” or “wrong.” Agreeing or disagreeing sends the subtle message that nurses have the right to make value judgments about the client’s decisions. Approving implies that the behaviour being praised is the only acceptable one, and disapproving implies that the client must meet the nurse’s expectations or standards. Instead, the nurse should help the client explore their own values, beliefs, goals, and decisions. For example, it is nontherapeutic to state, “You shouldn’t consider elective surgery; there are too many risks involved.” A more therapeutic response would be, “So you are considering elective surgery. Tell me more about the pros and cons of surgery.” This gives the client a chance to express their ideas or feelings without fear of being judged.
Giving Defensive Responses	When clients or family members express criticism, nurses should listen to what they are saying. Listening does not imply agreement. To discover reasons for the client’s anger or dissatisfaction, the nurse should listen without criticism, avoid being defensive or accusatory, and attempt to defuse anger. For example, if the client states, “Everyone here is lying to me,” it is not therapeutic to state, “No one here would intentionally lie to you.” Instead, a more therapeutic response would be, “You believe people have been dishonest with you. Tell me more about what happened.” (After obtaining additional information, the nurse may elect to follow the chain of command at the agency and report the client’s concerns for follow-up.)
Providing Passive or Aggressive Responses	Passive responses serve to avoid conflict or sidestep issues, whereas aggressive responses provoke confrontation. Passive responses serve to avoid conflict or sidestep issues, whereas aggressive communication provokes confrontation. Nurses should use assertive communication. For example, it is not therapeutic to state, “It’s your fault you are feeling ill because you don’t take your medication.” A therapeutic response would be, “Taking your prescribed medications every day can prevent symptoms from returning.” Nurses should use assertive communication as described in the “Basic Communication Concepts” section.
Arguing	Challenging or arguing against client perceptions denies that they are real and valid to the other person. They imply that the other person is lying, misinformed, or uneducated. The skillful nurse can provide information or present reality in a way that avoids argument. For example, it is not therapeutic to state, “How can you say you didn’t sleep a wink when I heard you snoring all night long!” A more therapeutic response would be, “You don’t feel rested this morning? Let’s talk about ways to improve your rest.”

Process Recordings

Process recordings are reflective learning activities with the objective of improving a student’s therapeutic communication skills. They include a transcript of the verbal and nonverbal responses between a student and a client during a therapeutic communication session. After the session, the transcript is analyzed by the student to identify therapeutic techniques, communication barriers or blocks, and the phases of the nurse-client relationship. The student evaluates the interaction to determine if the overall client-centred goal was met or not met, what went well during the conversation, and what they could improve in their therapeutic communication. As a result of the analysis, the student gains self-awareness regarding the

effectiveness of their communication and sets goals for self-improvement in future therapeutic communication sessions.

Strategies for Effective Communication

In addition to using therapeutic communication techniques and avoiding nontherapeutic responses, there are additional strategies for promoting effective communication when providing client-centred care. Specific questions to ask clients are as follows:

- What concerns do you have about your plan of care?
- What questions do you have about your medications?
- Did I answer your question(s) clearly, or is there additional information you would like (Smith, 2018)?

Listen closely for feedback from clients. Feedback provides an opportunity to improve client understanding, improve the client-care experience, and provide high-quality care. Other suggestions for effective communication with hospitalized clients include the following:

- Round with the providers and read progress notes from other health care team members to ensure you have the most up-to-date information about the client's treatment plan and progress. This information helps you to provide safe client care as changes occur and also to accurately answer the client's questions.
- Review information periodically with the client to improve understanding.
- Use client communication boards in their room to set goals and communicate important reminders with the client, family members, and other health care team members. This strategy can reduce call light usage for questions related to diet and activity orders, and also gives clients and families the feeling that they always know the current plan of care. However, keep client confidentiality in mind regarding information to publicly share on the board because the board can be seen by anyone entering the room.
- Provide printed information on medical procedures, conditions, and medications. It helps clients and family members to provide information in multiple ways (Smith, 2018).

Adapting Your Communication

When communicating with clients and family members, take note of your audience and adapt your message based on their characteristics, such as age, developmental level, cognitive abilities, communication disorders, and language differences.

Adapting communication according to the client's age, developmental level, and language differences includes the following strategies:

- When communicating with children, speak calmly and gently. It is often helpful to demonstrate what will be done during a procedure on a doll or stuffed animal. To establish trust, try using play or drawing pictures.
- When communicating with adolescents, give freedom to make choices within established limits.
- When communicating with older adults, be aware of potential vision and hearing impairments that commonly occur and address these barriers accordingly. For example, if a client has glasses and/or hearing aids, be sure these devices are in place before communicating. See the following box for evidence-based strategies for communication with clients who have impaired hearing and vision.
- For clients with language differences, it is vital to provide trained medical interpreters when important

information is communicated. Family members should not be used as translators because medical terms may not translate directly into the native language, and there is no way to determine if the information is being translated accurately. It is also possible that certain information is withheld from the client in the event the family does not want to burden them with upsetting information.

It is important to note that clients with communication disorders require additional strategies to ensure effective communication, which will be discussed later in this book.

Maintaining Confidentiality

When communicating with clients, their friends, family members, and other members of the health care team, it is vital that the nurse maintain client confidentiality. In Ontario, the **Personal Health Information Protection Act (PHIPA)** establishes enforceable standards for the privacy of client information. Nurses must always be aware of where and with whom they share client information. For example, client care information should not be discussed in public areas, paper charts must be kept in secure areas, computers must be logged off when walked away from, and client information should only be shared with those directly involved in client care.

Adapted from “2.3 Communicating With Patients” in Nursing Fundamentals 2e Copyright © 2024 by WisTech Open, which is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted. *Modifications: omitted sections on strategies for communicating with impaired hearing, vision, and speech.*

1.8 Basic Communication Concepts

Effective communication is one of the Standards of Professional Performance established by the American Nurses Association. The standard states, “The registered nurse communicates effectively in all areas of practice” (ANA, 2021). There are several concepts related to effective communication, such as demonstrating appropriate verbal and nonverbal communication, using assertive communication, being aware of personal space, and overcoming common barriers to effective communication.

Types of Communication

Verbal Communication

Effective communication requires each interaction to include a sender of the message, a clear and concise message, and a receiver who can decode and interpret that message. The receiver also provides a feedback message back to the sender in response to the received message. See Figure 1.8.1 for an image of effective communication between a sender and receiver.

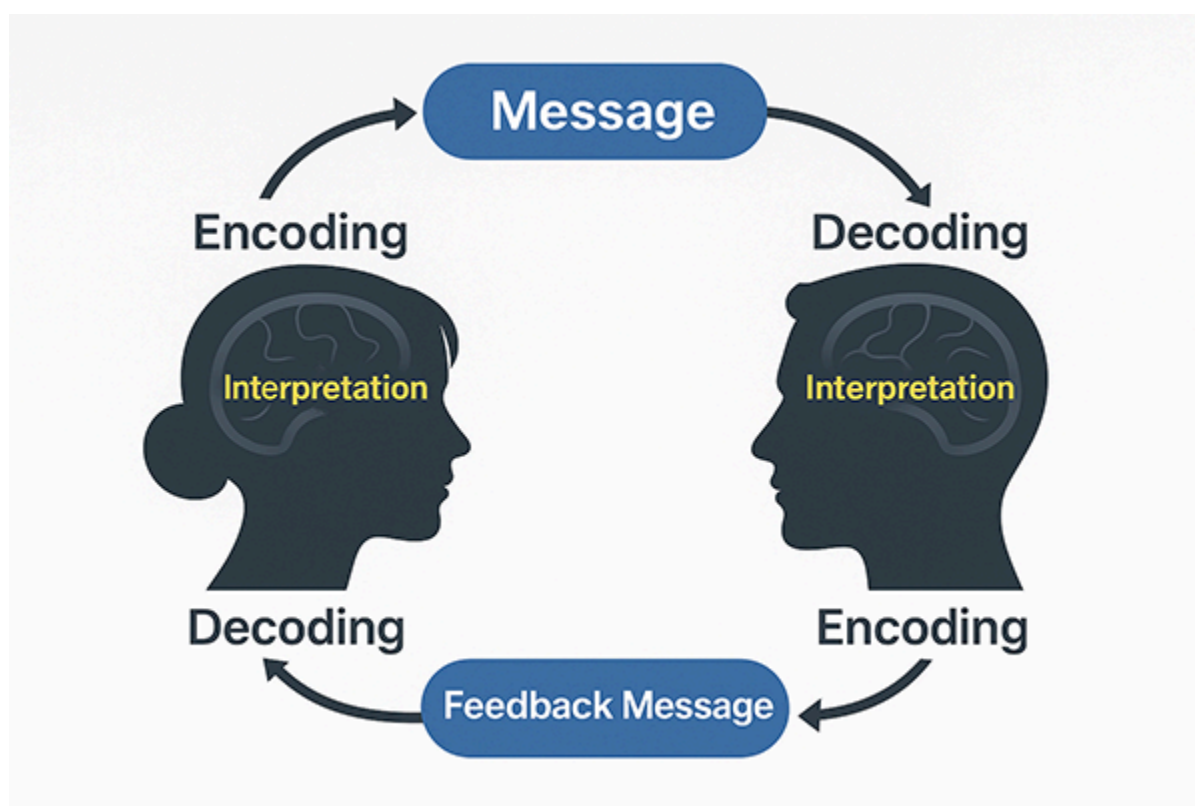


Figure 1.8.1: Effective Communication. “Osgood-Schramm-model-of-communication.jpg” by Jordan Smith, OpenAI (2025).

Nurses assist clients and their family members to understand health care needs and treatments by using verbal, nonverbal, and written communication. Verbal communication is more than just talking. Effective **verbal communication** is defined as an exchange of information using words understood by the receiver in a way

that conveys professional caring and respect (Anonymous, 2024). Nurses who speak using extensive medical jargon or slang may create an unintended barrier to their own verbal communication processes. When communicating with others, it is important for the nurse to assess the receiver's preferred method of communication and individual receiver characteristics that might influence communication, and subsequently adapt communication to meet the receiver's needs. For example, the nurse may adapt postsurgical verbal instruction for a pediatric versus an adult client. Although the information requirements regarding signs of infection, pain management, etc., might be similar, the way in which information is provided may be quite different based on developmental level. Regardless of the individual adaptations that are made, the nurse must be sure to always verify client understanding.

Nonverbal Communication

In addition to communicating verbally, the nurse must also be aware of messages sent by **nonverbal communication**. Nonverbal communication includes facial expressions, tone of voice, pace of the conversation, and body language. Nonverbal communication is more powerful than the verbal message and can have a tremendous impact on the communication experience, with up to 80% of communication being nonverbal communication (see Figure 1.8.2). The importance of nonverbal communication during communication has also been described in percentages of 55, 38, and 7, meaning 55% of communication is body language, 38% is tone of voice, and 7% is the actual words spoken.

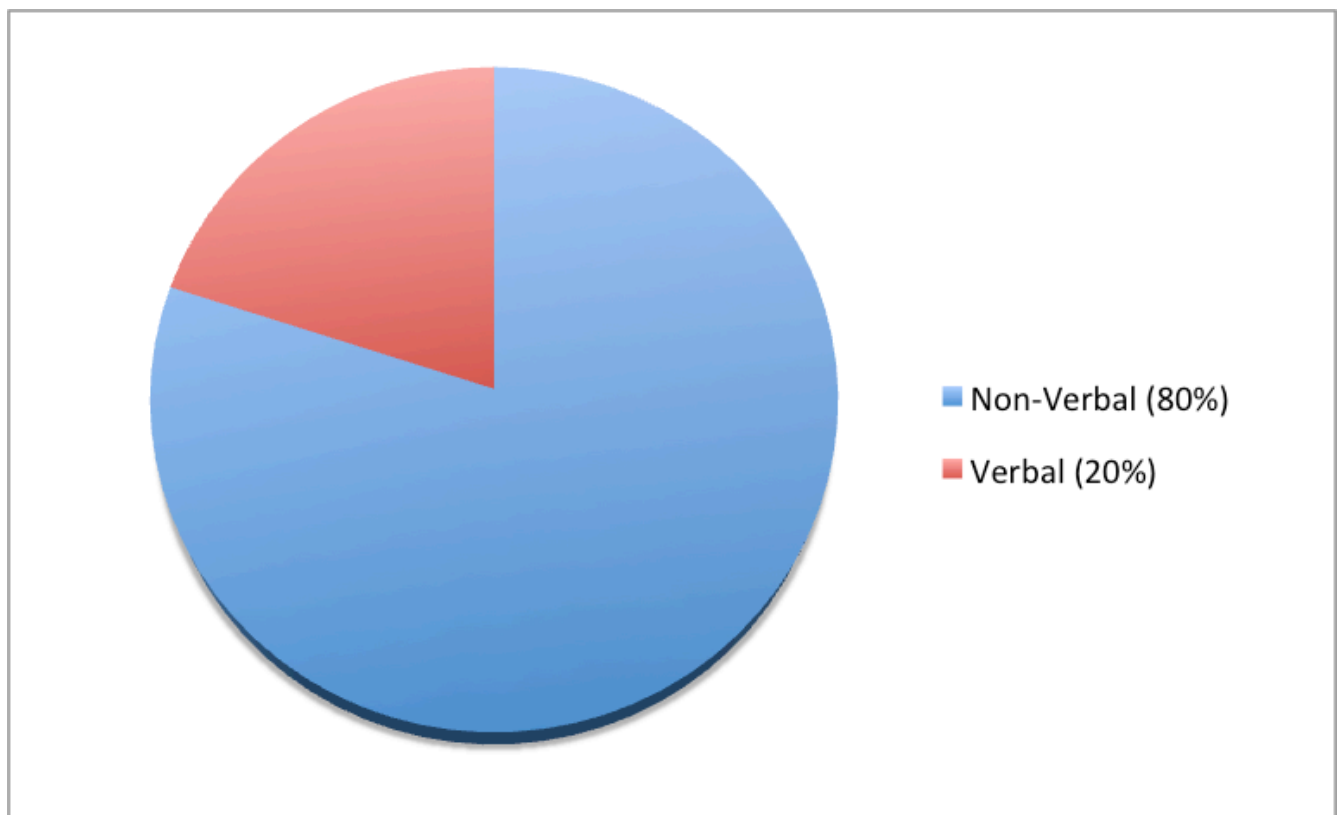


Figure 1.8.2: Nonverbal Communication. "Constituents of Communication.png" by jb1lko, lb13an, ad14xz, jb12xu, CC BY-SA 4.0.

Nonverbal communication includes body language and facial expressions, tone of voice, and pace of the con-

versation. For example, compare the nonverbal communication messages in Figure 1.8.3 & 1.8.4. What nonverbal cues do you notice about both toddlers?



Figure 1.8.3: Toddler's Nonverbal Communication. "I'm angry" by WiLPrZ), CC BY-NC-ND 2.0.



Figure 1.8.4: Toddler's Nonverbal Communication. "Happy Toddler" by Chris Bloom, CC BY-SA 2.0.

Nurses should be attentive to their nonverbal communication cues and the messages they provide to clients and their families. Nurses should be purposeful in their use of nonverbal communication that conveys a feeling of caring (Anonymous, 2024). What nonverbal cues do you notice about the nurse in Figure 1.8.5 that provide a perception of professional caring?



Figure 1.8.5: Nurse's Nonverbal Communication. "PIXNIO-42752-4542×3003.jpg" by James Gathany, Judy Schmidt, USCDCP, CCO 1.0.

Nurses use nonverbal communication such as directly facing clients at eye level, leaning slightly forward, and making eye contact to communicate they care about what the person is telling them and they have their full attention (Stickley, 2011).

Engagement in the Communication Exchange

It is common for health care team members in an acute care setting to enter a client's room and begin interacting with a client who is seated or lying in bed. However, it is important to remember that initial or sensitive communication exchanges are best received by the client if the nurse and client are at eye level. Bringing a chair to the client's bedside can help to facilitate engagement in the communication exchange. SOLER is a common mnemonic used to facilitate nonverbal communication (sit with open posture and lean in with good eye contact in a relaxed manner).

Communication Styles

In addition to verbal and nonverbal communication, people communicate with others using one of three

styles: passive, aggressive, or assertive. A passive communicator puts the rights of others before their own. Passive communicators tend to be apologetic or sound tentative when they speak and often do not speak up if they feel they are being wronged. Aggressive communicators, on the other hand, come across as advocating for their own rights despite possibly violating the rights of others. They tend to communicate in a way that tells others their feelings don't matter. Assertive communicators, in contrast, respect the rights of others while also standing up for their own ideas and rights when communicating. An assertive person is direct, but not insulting or offensive (Anonymous, 2024). **Assertive communication** refers to a way of conveying information that describes the facts and the sender's feelings without disrespecting the receiver's feelings. Using "I" messages such as, "I feel...", "I understand...", or "Help me to understand..." are strategies for assertive communication. This method of communicating is different from aggressive communication that uses "you" messages and can feel as if the sender is verbally attacking the receiver rather than dealing with the issue at hand. For example, instead of saying to a coworker, "Why is it always so messy in your clients' rooms? I dread following you on the next shift!," an assertive communicator would use "I" messages to say, "I feel frustrated spending the first part of my shift decluttering our clients' rooms. Help me understand why it is a challenge to keep things organized during your shift?"

Using assertive communication is an effective way to solve problems with clients, coworkers, and healthcare team members.



Watch: How to Communicate Assertively 4

Video: "How to Communicate Assertively 4 Tips" by Communication Coach Alexander Lyon [9:54] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Personal Space

While being aware of verbal and nonverbal messages and communicating assertively, it is also important to be aware of others' personal space. Proxemics is the study of personal space and provides guidelines for professional communication. The public zone is over 10 feet of distance between people and generally avoids physical contact. The social zone is four to 10 feet of distance between people. It is used during social interactions and business settings. The personal zone is 18 inches to four feet of space and is generally reserved for friends and family. Less than 18 inches is reserved for close relationships but may be invaded when in crowds or playing sports (Psychology Today, 2025). Nurses usually communicate within the social zone to maintain professional boundaries. However, when assessing clients and performing procedures, nurses often move into a client's personal zone. Nurses must be aware of clients' feelings of psychological discomfort that can occur when invading this zone. Additionally, cultural considerations may impact the appropriateness of personal space when providing client care. See Figure 1.8.6 for an example of personal space zones (Psychology Today, 2025).

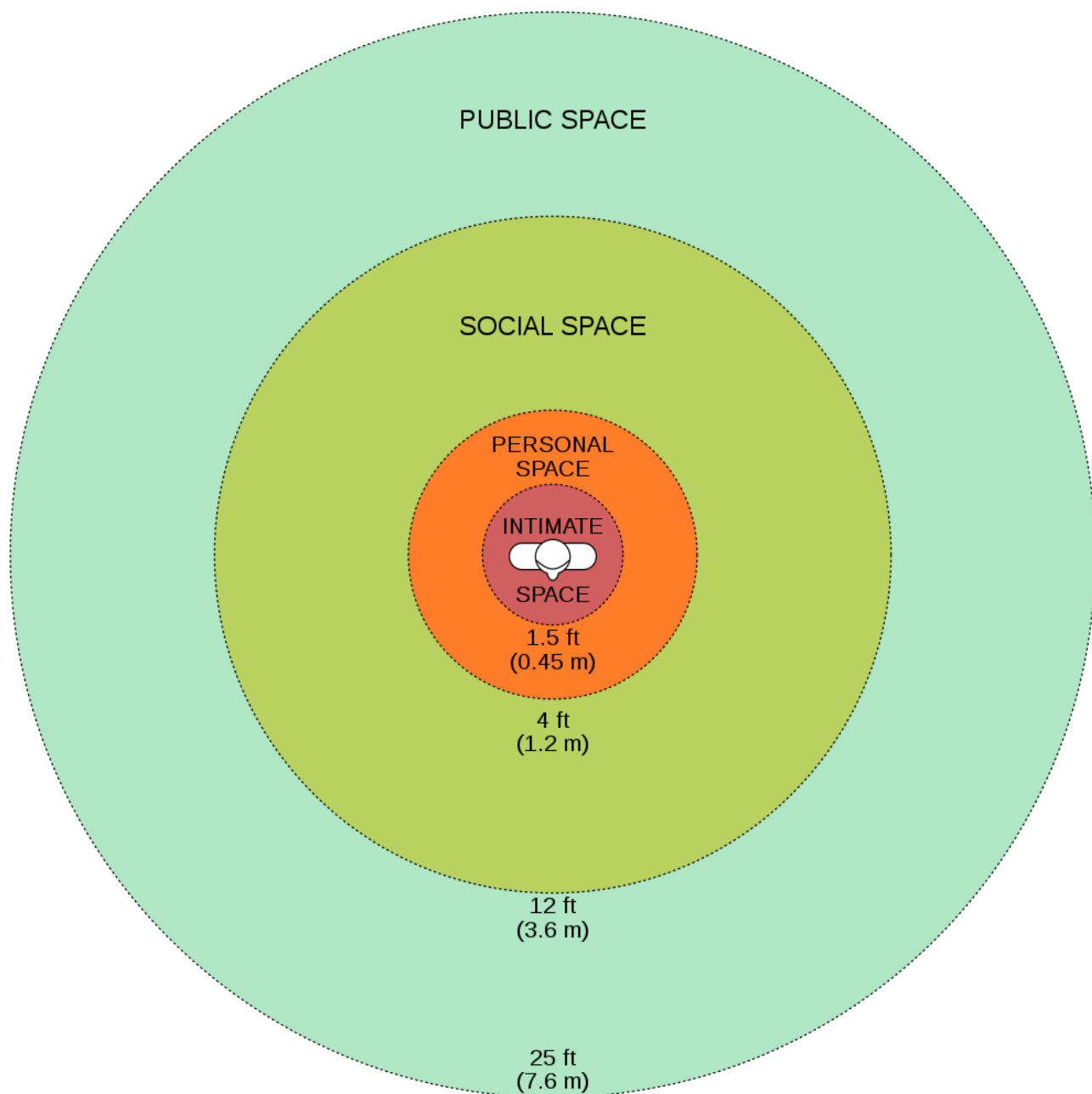


Figure 1.8.6. "Personal Space" by WebHamster, CC BY-SA 3.0.

Overcoming Common Barriers to Communication

Nurses must reflect on personal factors that influence their ability to communicate effectively. There are many factors that can cause the message you are trying to communicate to become distorted and not perceived by the receiver in the way you intended. For this reason, it is important to seek feedback to ensure that your message is clearly understood. Nurses must be aware of these potential barriers and try to reduce their impact by continually seeking feedback and checking understanding (SkillsYouNeed, n.d.).

Common Barriers to Communication

Some common barriers to communication in health care and strategies to overcome them are as follows:

- **Jargon:** Avoid using medical terminology, complicated, or unfamiliar words. When communicating with clients, explain information in plain language that is easy to understand by those without a medical or nursing background.
- **Lack of attention:** Nurses are typically very busy with several tasks to complete for multiple clients. It is easy to become focused on the tasks instead of the client. When entering a client's room, it is helpful to pause, take a deep breath, and mindfully focus on the client in front of you to give them your full attention. Clients should feel as if they are the center of your attention when you are with them, no matter how many other things you have going on.
- **Noise and other distractions:** Health care environments can be very noisy with people talking in the room or hallway, the TV playing, alarms beeping, and pages being overhead. Create a calm, quiet environment when communicating with clients by closing doors to the hallway, reducing the volume of the TV, or moving to a quieter area, if possible.
- **Light:** A room that is too dark or too light can create communication barriers. Ensure the lighting is appropriate according to the client's preference.
- **Hearing and speech problems:** If your client has hearing or speech problems, implement strategies to enhance communication. See the "Adapting Your Communication" subsection below for strategies to address hearing and speech problems.
- **Language differences:** If English is not your client's primary language, it is important to seek a medical interpreter and to also provide written handouts in the client's preferred language when possible. Most agencies have access to an interpreter service available by phone if they are not available on-site.
- **Differences in cultural beliefs:** The norms of social interaction vary greatly in different cultures, as well as the ways that emotions are expressed. For example, the concept of personal space varies among cultures, and some clients are stoic about pain, whereas others are more verbally expressive. Read more about caring for diverse clients in the "Diverse Patients" chapter.
- **Psychological barriers:** Psychological states of the sender and the receiver affect how the message is sent, received, and perceived. For example, if nurses are feeling stressed and overwhelmed with required tasks, the nonverbal communication associated with their messages, such as a lack of eye contact, a hurried pace, or a short tone, can affect how the client perceives the message. If a client is feeling stressed, they may not be able to "hear" the message, or they may perceive it differently than it was intended. It is important to be aware of the signs of the stress response in ourselves and our clients and implement appropriate strategies to manage the stress response. See the box below for more information about strategies to manage the stress response.
- **Physiological barriers:** It is important to be aware of clients' potential physiological barriers when communicating. For example, if a client is in pain, they are less likely to hear and remember what was said, so pain relief should be provided as needed before providing client education. However, it is also important to remember that sedatives and certain types of pain medications often impair the client's ability to receive and perceive messages, so health care documents cannot be signed by

a client after receiving these types of medications.

- **Physical barriers for nonverbal communication:** Providing information via e-mail or text is often less effective than face-to-face communication. The inability to view the nonverbal communication associated with a message, such as tone of voice, facial expressions, and general body language, often causes misinterpretation of the message by the receiver. When possible, it is best to deliver important information to others using face-to-face communication so that nonverbal communication is included with the message.
- **Differences in perception and viewpoints:** Everyone has their own beliefs and perspectives and wants to feel “heard.” When clients feel their beliefs or perspectives are not valued, they often become disengaged from the conversation or the plan of care. Nurses should provide health care information in a nonjudgmental manner, even if the client’s perspectives, viewpoints, and beliefs are different from their own (SkillsYouNeed, n.d.).

Learn more about Barriers to Effective Communication.

Managing the Stress Response

The stress response is a common psychological barrier to effective communication. It can affect the message sent by the sender or how it is received by the receiver. The stress response is a common reaction to life events, such as a nurse feeling stressed by being overwhelmed with tasks to complete for multiple clients, or a client feeling stressed when admitted to a hospital or receiving a new diagnosis. Symptoms of the stress response include irritability, sweaty palms, a racing heart, difficulty concentrating, and impaired sleep. It is important to recognize symptoms of the stress response in ourselves and our clients and use strategies to manage the stress response when communicating.

Strategies to Manage Stress Response

Strategies to manage the stress response include the following:

1. Use **relaxation breathing**. Become aware of your breathing. Take a deep breath through your nose and blow it out through your mouth. Repeat this process at least three times in succession and then as often as needed throughout the day.
2. Make healthy diet choices. Avoid caffeine, nicotine, and junk food because these items can increase feelings of anxiety or being on edge.
3. Make time for exercise. Exercise stimulates the release of natural endorphins that reduce the body’s stress response and also helps to improve sleep.
4. Get enough sleep. Set aside at least 30 minutes before going to bed to wind down from the busyness of the day. Avoid using electronic devices like cell phones before bedtime because the backlight can negatively impact sleep.
5. Use **progressive relaxation**. There are several types of relaxation techniques that focus on reducing muscle tension and using mental imagery to induce calmness. Progressive relaxation generally

includes the following steps:

- Start by lying down somewhere comfortable and firm, such as a rug or mat on the floor. Get yourself comfortable.
- Relax and try to let your mind go blank. Breathe slowly, deeply, and comfortably, while gradually and consciously relaxing all your muscles, one by one.
- Work around the body one main muscle area at a time, breathing deeply, calmly, and evenly. For each muscle group, clench the muscles tightly and hold for a few seconds, and then relax them completely. Repeat the process, noticing how it feels. Do this for each of your feet, calves, thighs, buttocks, stomach, arms, hands, shoulders, and face (American Psychological Association [APA], 2019).



Watch: On Communication

Therapeutic vs Non-Therapeutic Explained

Video: “Effective Nursing Communication Made Easy | Therapeutic vs Non-Therapeutic Explained” by StudynurseIQ [10:13] is licensed under the Standard YouTube License. Transcript and closed captions available on YouTube.

Poor Communication

Video: “Poor Communication” by contextofcare [2:54] is licensed under the Standard YouTube License. Transcript and closed captions available on YouTube.

Good Nurse, Bad Nurse

Video: “Good Nurse, bad nurse” by PontiacPrincess1 [4:56] is licensed under the Standard YouTube License. Transcript and closed captions available on YouTube.

Links to Learning

- Guide to Therapeutic Communication: 17 Core Techniques for Nurses to Provide Better Patient Care and Improve Results from Nightingale College.

- The SOLER Model Script [PDF]
- Foundational Communication Skills: The OARS Model [PDF]
- Book: Strengths-based nursing care: health and healing for person and family (Gottlieb, 2013)

From Theory to Practice

The nurse finds a patient crying during night rounds. During the change of shift report, the nurse was informed that the patient was scheduled for surgery in the morning. The nursing team working on days stated they got all the documents signed, and the resident came to speak to the patient and clarified information about the surgery. The patient was in good spirits and felt relieved to finally get it because it had been cancelled a few times.

What would you say and do? How might you apply the core components of the TNCR, cultural humility, and therapeutic communication techniques while practicing from a trauma-informed and SBNH perspective?

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1.9 Chapter Summary



Key Takeaways

The TNCR is the context in which nursing care occurs across settings and patient populations. The nurse uses effective therapeutic communication techniques to learn what is important to the patient, values, beliefs, goals, impact of illnesses, challenges, and coping strategies. It is only by learning about the patient's story that the nurse can assess, provide, and evaluate the effectiveness of the care provided.



Knowledge Check

Quiz Text Description

1. MultiChoice Activity

Which core component of the TNCR is demonstrated when a nurse provides their name, designation, and information about a procedure to the client before administering care?

- a. Respect
- b. Compassion
- c. Empathy
- d. Professional intimacy

2. MultiChoice Activity

A patient tells the nurse that they cannot sleep due to the pain they experience at night. Which of the following statements is an empathetic response?

- a. I am so sorry you cannot sleep at night. I will let the doctor know about it.
- b. I understand how challenging it can be to get some rest when you are in pain. Tell me more about what you feel at night.
- c. I will get the doctor to give you something for pain right away.
- d. Are you sure you cannot sleep because of pain? Is there anything else going on at night?

3. MultiChoice Activity

The nurse notices that a newly admitted resident is not eating very much. When administering medications in the resident's room, the nurse notices pictures that indicate the resident grew up in Mexico. When the resident's daughter visits her mother, which statement demonstrates the nurse's cultural humility?

- a. Your mother does not like our food. Can you tell me what kind of food you eat in Mexico?
- b. Your mother does not eat very much. We only get tacos on Tuesdays.
- c. I have noticed that your mom is not eating very much. Can you please tell me about her eating habits at home?
- d. Your mother is not eating very much. Can you bring some of your food for her to eat?

4. MultiChoice Activity

Which of the following is NOT one of the six guiding principles of trauma-informed care?

- a. Empowerment, voice, and choice
- b. Safety (physical and psychological)
- c. Paternalistic clinical decision-making

- d. Trustworthiness and transparency

5. MultiChoice Activity

A nurse is conducting a strengths-based assessment on a patient newly diagnosed with diabetes. Which question is most appropriate?

- a. "Do you understand that failing to follow this diet will lead to serious complications?"
- b. "What have you done in the past that has helped you successfully manage difficult health challenges?"
- c. "Why didn't you come to the clinic sooner when you noticed your symptoms?"
- d. "Which of these pre-printed goals from our standard care plan do you want to start with?"

6. MultiChoice Activity

A patient with a new diagnosis of heart failure says, "I don't know if I can handle all these medications and lifestyle changes." Which response by the nurse is most therapeutic?

- a. "It sounds like you're feeling overwhelmed by these changes."
- b. "Why do you think you won't be able to handle it?"
- c. "Don't worry, you'll get the hang of it in no time."
- d. "My grandfather had this and he did just fine."

7. MultiChoice Activity

Which of the following is an example of the therapeutic technique "Clarifying"?

- a. "I think you should talk to your doctor about that."
- b. "I will be back in 30 minutes to check on you."
- c. "Are you saying you want to go home today?"
- d. "I'm not sure I follow. Could you explain what you meant by 'feeling trapped'?"

8. MultiChoice Activity

When the nurse says to a patient, "You shouldn't feel that way about your daughter; she's only trying to help," the nurse is non-therapeutic by

- a. being assertive.
- b. giving personal opinions/advice.
- c. changing the subject.
- d. providing false reassurance.

9. MultiChoice Activity

A patient tells the nurse, "I'm so scared about my surgery tomorrow." The nurse replies, "The surgeons here are the best in the country; you're in great hands." This response is non-therapeutic because it

- a. is too technical for the patient to understand.
- b. encourages the patient to ask more questions.
- c. uses a professional tone.
- d. provides false reassurance and dismisses the patient's feelings.

10. MultiChoice Activity

Which question is the best example of an open-ended statement?

- a. "Did you sleep well last night?"
- b. "How have you been managing your symptoms at home?"
- c. "Are you in pain right now?"
- d. "Do you have any allergies to medication?"

Solution:

- 1. a. Respect
- 2. b. I understand how challenging it can be to get some rest when you are in pain. Tell me more about what you feel at night.
- 3. c. I have noticed that your mom is not eating very much. Can you please tell me about her eating habits at home?
- 4. c. Paternalistic clinical decision-making
- 5. b. "What have you done in the past that has helped you successfully manage difficult health challenges?"
- 6. a. "It sounds like you're feeling overwhelmed by these changes."
- 7. d. "I'm not sure I follow. Could you explain what you meant by 'feeling trapped'?"
- 8. b. giving personal opinions/advice.
- 9. d. provides false reassurance and dismisses the patient's feelings.
- 10. b. "How have you been managing your symptoms at home?"



For Further Reflection

Video: "

How Does Self-awareness Impact Therapeutic Communication? – Nursing Knowledge Exchange" by Nursing Knowledge Exchange [3:14] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

What would you do and say as the nurse?



3-Week-old Baby and Mom Case Study Analysis

Review the scenario

Key Points

- Introduce yourself as the (student) nurse and let the mom know what you will be doing. Let mom know that all the information obtained is private, confidential, and will only be shared with the doctor and any other members of her health care team
- Ask Mom how she has been feeling. Is she doing ok? Does she get any help with the baby and the house? Is she able to sleep, eat, and look after herself? Does mom have any questions? Inquire about mom's body care and baby's body care
- Based on what mom says, clarify and validate as needed. Use verbal and non-verbal therapeutic communication skills as needed. Remind the mom that she is going through many changes. It is ok to have questions and experience many different feelings. Teach mom about the changes in her body, including hormone regulation. Provide emotional support as needed. Assess mom's body and then check Macy to ensure they are well.
- Assess/inquire about the baby's routine, feeding habits, sleeping, exercise, and elimination patterns. Clarify, validate and teach mom about skin care, infection control, prevention and management of dermatitis (diaper rash) and candida (thrush of skin and mouth for the baby and mom's nipples).
- Ask mom whether she is interested in a referral to counselling services and, as needed, social work. Inquire about social and family support. Offer to connect with new mom groups.

CHAPTER 2: PROFESSIONAL, ETHICAL, AND LEGAL NURSING RESPONSIBILITIES — PRIVACY & CONFIDENTIALITY

Chapter Overview



- 2.0 Learning Objectives
- 2.1 Chapter Introduction
- 2.2 Professional Nursing Practice
- 2.3 Ethical Nursing Practice
- 2.4 Legal Responsibilities
- 2.5 Privacy and Confidentiality
- 2.6 Boundaries
- 2.7 Chapter Summary

2.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Locate the application of Standards of Practice and Guidelines from the College of Nursing of Ontario
2. Apply professional, ethical, and legal responsibilities of nursing practice in Ontario
3. Analyze the application of privacy and confidentiality laws and principles to nursing practice
4. Describe the impact of professional boundaries in the TNCR to ensure safe, competent, ethical, caring, and compassionate nursing practice for all patients
5. Explain the impact of racism on health, wellness and healing to determine possible ways to practice from an antiracist nursing philosophy perspective

2.1 Chapter Introduction

Nurses provide care to individuals, families, and communities in a wide variety of settings. Nursing is a profession based on collaborative relationships with clients and colleagues. To ensure the safety of the public anywhere in the world, the profession of nursing requires that nurses be authorized to practice before they provide care to people. All countries have professional, ethical, legal, and organizational principles that govern the profession of nursing. For example, a nurse who is registered to practice in Canada must also be registered-authorized to practice nursing in another country before they can work in a professional nursing capacity. Practicing nursing without the required education and authorization is unsafe, unethical, illegal, and does not reflect competency and the values of professional nursing practice (Bonilla and Beukeboom, 2017).



Watch: ICN Nursing Definitions

Video: “Webinar Recording: Embedding the ICN Nursing Definitions EN” by ICN-International Council of Nurses [0:00] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

In Canada, there are four categories of regulated nurses that include Registered Nurses (RNs), Licensed Practical Nurses (LPNs who are referred to as Registered Practical Nurses (RPNs) in Ontario and Nursing Assistants in Quebec); Registered Psychiatric Nurses (RPNs); and Nurse Practitioners (NPs). The practice of nursing includes the areas of health promotion, clinical care (bedside nursing), education (formal training and education of the profession), research, and policy development (Covell et al., 2023).

Note

In this OER, the designation of nurse refers to the practice of Registered Nurses (RNs) in Canada and the province of Ontario.

Canadian RNs must obtain a Bachelor of Science in Nursing and pass a licensing examination (NCLEX-RN) to hold the title of RN and practice nursing. In Canada, nursing is a self-regulated profession. Nursing regulatory authorities in each province and territory are responsible for ensuring that RNs are safe, competent, compassionate, and ethical practitioners.



Watch: Nursing Statistics Report 2025

Video: “Nursing Statistics Report 2025” by The College of Nurses of Ontario (CNO) [1:37] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



What would you do and say as the nurse?

TJ is 20 years old. They are struggling with college, work, and life in general. TJ is in the ER complaining of increased headaches for the past month. They are unable to concentrate on schoolwork. TJ tells you they have been losing weight, but that is ok because it has helped them stay in shape. Due to school and work, TJ cannot go out with friends as much as they like, and their social life is on the “dumps”. They have lots of friends on social media, which has become their main way to communicate, make friends, and date people. TJ declares that you are an awesome person and “such a catch ‘cause you’re an excellent nurse!” TJ thinks that you are easy-going and a really cool person. They trust you 100%, so they want to connect and keep the relationship going further on social media. TJ also asks for your number so you can “hang out some time online or IRL and text each other”.

2.2 Professional Nursing Practice

In Canada, regulatory professional nursing organizations in each province or territory achieve their mandate through a variety of regulatory activities, including registration and licensure, professional conduct reviews, scope-of-practice descriptions, and the development of standards of nursing practice and education. The professional nursing regulatory organizations also identify the competencies required for entry-to-practice nursing in Canada (Canadian Nurses Association [CNA], n.d.-a). The professional self-regulation of nursing practice in Canada assures the public that individuals who hold the title of RN, LPN, RPN or NP provide high-quality, safe, competent, and ethical care following professional, ethical, and legal responsibilities of Canadian nursing practice.

In Ontario, the professional regulatory nursing organization is the *College of Nurses of Ontario* (CNO). Other important professional nursing organizations that guide the practice of nursing include the *International Council of Nurses* (ICN), the *Canadian Nurses Association* (CNA), and the *Registered Nurses Association of Ontario* (RNAO).

According to ICN, a nurse is a professional who is educated in the scientific knowledge, skills and philosophy of nursing, and regulated to practice nursing (ICN, n.d.).

Nursing Definitions

ICN's definitions of 'nursing' and 'a nurse' provide an authoritative articulation of the profession's scope, identity and contribution to global health.



Image: "Woman in Tank Top" by Carlos Magno, Unsplash License.

2.2.1 Standards of Practice and Guidelines (CNO)

Nursing is an art and a science (Jasmine, 2009). Nurses must acquire and apply different types of knowledge that must be balanced with technical skills and a conscious and purposeful commitment to include caring behaviours during each nurse-client interaction.

In Ontario, the College of Nurses of Ontario (CNO) provides practice standards and guidelines to support nurses in providing safe and ethical nursing care to the people of Ontario. Practice standards outline the expectations for nurses that contribute to public protection. Practice guidelines help nurses understand their responsibilities and how to make safe and ethical decisions in their practice (CNO, n.d.-a).

The Code of Conduct (Code) is a practice standard describing the accountability all nurses registered in Ontario have to clients, employers, colleagues and the public. It explains what people can expect from nurses. The Code also describes what nurses must do to maintain professionalism, competence, and ethical behaviour to deliver safe client care. All nurses (Registered Nurses, Registered Practical Nurses, and Nurse Practitioners) are expected to uphold this practice standard, regardless of their role, title or responsibility. To maintain public trust and confidence in the nursing profession's integrity and care, the Code outlines safe and ethical practice requirements based on current evidence. The Code is also informed by legislation, such as the Ontario Human Rights Code and recommendations in the Truth and Reconciliation Commission of Canada: Calls to Action (2015).

Principles of the Code

The Code of Conduct consists of six principles:

Principle 1

Nurses respect clients' dignity.

Principle 2

Nurses provide inclusive and culturally safe care by practicing cultural humility.

Principle 3

Nurses provide safe and competent care

Principle 4

Nurses work respectfully with the health care team.

Principle 5

Nurses act with integrity in clients' best interest.

Principle 6

Nurses maintain public confidence in the nursing profession.

Each principle is supported by a set of statements of core behaviours that all nurses are accountable for. All principles have equal importance and work together to describe the conduct, behaviour, and professionalism necessary for safe and ethical nursing practice in Ontario (CNO, 2026a).



Watch: Modernized Code of Conduct

Video: "Modernized Code of Conduct Video (English)" by The College of Nurses of Ontario (CNO) [1:52] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

2.2.3 Best Practice Guidelines BPGs (RNAO)

The Registered Nurses Association of Ontario (RNAO) has developed more than 50 guidelines to promote evidence-based practice in nursing care (RNAO, n.d.). They are evidence-based, systematically developed guidelines that include recommendations for nurses, interprofessional health teams, educators, leaders and policymakers regarding how to improve outcomes for people and their support networks in the health care system.



Watch: RNAO Best Practice Guidelines

Video: “RNAO Best Practice Guidelines Program overview” by RNAO Communications [5:03] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

A first-year student nurse is preparing to practice with standardized patients (SPs) in the weekly lab. The student nurse is very excited to wear scrubs and start looking like a nurse. Some classmates are discussing how to wear their scrubs and their hair. They are considering getting manicures and wearing special jewelry for “good luck”. They love certain nursing images portrayed by some actors in trendy shows, and the way some nurses look on social media.

What must the first-year student nurse and their classmates do? What would you do following professional, ethical, and legal responsibilities of nursing practice?

2.3 Ethical Nursing Practice

The Canadian Nurses Association Code of Ethics for Nurses is an ethical framework based on seven values that emphasize key areas, including reconciliation and anti-racism, nurse well-being, contemporary challenges, leadership, and language. The seven core values include dignity, relationships, integrity, truth/reconciliation, social justice, competence, and confidentiality (CNA, 2025). The CNA Code of Ethics guides Canadian nurses' ethical decision-making and promotes safe, compassionate, and accountable care across all practice settings.

The International Council of Nurses Code of Ethics for Nurses outlines the ethical responsibilities, values, and accountabilities of nurses worldwide. It focuses on four core elements—nurses and patients, practice, profession, and global health—that aim to promote health, prevent illness, and alleviate suffering. According to the ICN Code of Ethics, nurses have four fundamental responsibilities: promoting health, preventing illness, restoring health, and alleviating suffering (ICN, 2021).

The CNA Code of Ethics and the ICN Code of Ethics are frameworks designed to be used in conjunction with local laws and professional nursing regulations. They both emphasize that nursing care is respectful of and unrestricted by considerations of the client's age, colour, creed, culture, disability, gender, or sexual orientation.



Watch: On Ethics

Moral Distress in Nursing

Video: “Nursing Ethics: Moral Distress in Nursing” by Johns Hopkins University School of Nursing [2:04] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Handling Ethical Dilemmas

Video: “Nursing Ethics Explained: Handling Ethical Dilemmas in Practice 📖” by Lecturio Nursing [6:21] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Ethical Principles in Nursing

Video: “Ethical Principles in Nursing | NCLEX Study Tips | NurseInTheMaking” by NurseInTheMaking [6:52] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

2.3.1 Racism in Health Care

Race is an important determinant of health, with racism contributing to longstanding health and social

inequities. Racism in health care and nursing is a systemic problem that leads to discrimination and health disparities. These issues need to be tackled aggressively at all levels (CNA, 2026).

In 2020, CNA initiated a comprehensive research project to explore racism and develop strategies for change. This groundbreaking study is the first step towards creating a more inclusive and equitable nursing workforce in Canada.

Racism in Health Care

CNA Findings on Racism



Watch: B.C. Anti-racism Work

Video: "Indigenous man's death spurs B.C. nursing college's anti-racism work" by CBC British Columbia [5:28] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Links to Learning

- Hearing our voices (part 1): facilitating nurses' reflection on taking anti-racist action
- Hearing our voices (part 2): empowering nurses to take anti-racist action in health care
- Why Representation in Nursing Textbooks Matters More Than You Think....
- Experiences of Discrimination in Nursing Practice: A Focus on Racism [PDF]. CNO conducted a Workforce Census survey in February 2024 to understand the experiences of nurses affected by racism and other forms of bias. A descriptive snapshot of respondents' experiences is provided to build awareness and provide evidence on barriers to safe workplaces and quality practice settings.
- Anti-Racism Guideline for Registered Nurses (College of Registered Nurses of Saskatchewan [PDF], 2026)

Nursing Specific Resources

- The University of British Columbia, School of Nursing, Antiracism Committee
Promoting Anti-Racism in Nursing Education in Canada. CASN Anti-Racism in Nursing Education
- Working Group [PDF]
(2023)

Allyship

- Guide to Allyship
- American Association of Colleges of Nursing Allyship (2026)
 - See the *Reflection* section for the questions and exercises to consider with your classmates

Establishing Professional Boundaries

Professional boundaries in nursing practice are necessary to ensure the safety of all patients. Safety relates to the physical, emotional, psychological, spiritual, sexual, and cultural well-being of people. Nurses must also feel safe to practice, which promotes safe, competent, ethical, caring, and compassionate nursing care. Establishing a TNCR and following professional, ethical and legal guidelines does not mean that the nurse must accept and expect disrespectful, uncivilized, racist, and abusive behaviour from patients and colleagues.

Discontinuing Nursing Care

Nursing care is sometimes discontinued when there is a significant breakdown in the therapeutic nurse-client relationship, to the point that a nurse can no longer meet their professional obligations to the client. This occurs when one or more components of the therapeutic nurse-client relationship (that is, trust, respect, and empathy) are significantly damaged (CNO, 2026).

Declining to Provide Care

Nurses may consider declining to provide care when the situation is beyond their competence, a conflict of interest exists (e.g., conscientious objection), or they believe the situation poses an unacceptable level of risk to them or their client, including abuse or threatening language (CNO, 2026).

See CNA's *Professional Boundaries and Nurse-Client Relationships [PDF]*



Watch: Discontinuing or Declining to Provide Care

Video: "Discontinuing or Declining to Provide Care Webinar recording (English)" by The College of Nurses of Ontario (CNO) [12:50] is licensed under the Standard YouTube License. Transcript and closed captions available on YouTube.

From Theory to Practice

A newly graduated nurse prepares to start an intravenous (IV) medication administration. The nurse checks applicable organization protocols and standards of practice to ensure compliance with professional, ethical, and legal responsibilities. When the nurse informs the patient about the procedure to obtain consent, the patient refuses the IV. They state they do not want to be cared for by a new, inexperienced nurse. The patient's family is present. They tell the nurse they want to speak to the manager so their loved one can be properly cared for by a white nurse who speaks English and knows what they are doing.

What must the newly graduated nurse do? What would you do following professional, ethical, and legal responsibilities of nursing practice?

2.4 Legal Responsibilities

The legal nursing responsibilities in Ontario follow the Regulated Health Professions Act (RHPA) and the Nursing Act, 1991, which require nurses (RNs, RPNs, NPs) to practice safely, ethically, and competently according to the CNO. The functions of the College include setting out the requirements for entry to practice and standards, enforcing a Code of Conduct, and handling professional misconduct. Key legal duties of nurses in Ontario include having the legal authority to perform procedures, obtaining informed consent, maintaining confidentiality, and following all the standards of practice while maintaining professional boundaries. It is illegal for people to use the titles “Nurse,” “Registered Nurse” (RN), “Registered Practical Nurse” (RPN), or “Nurse Practitioner” (NP) in Ontario without a valid CNO certificate of registration (CNO, n.d.-b). Nursing is a self-regulated profession; therefore, nurses are personally accountable for their own practice and conduct regardless of their place of work. They usually work in hospitals, long-term care, and community settings (CNO, n.d.-c)

2.4.1 Scope of Practice

The Nursing Act (1991) states that the practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. To protect the public and ensure their safety, specific authorized acts that can be performed by nurses based on their knowledge and experience are clearly outlined. In Ontario, nurses are accountable for knowing and must follow the Controlled Act model outlined in the Nursing Act (1991). Controlled acts, such as the administration of intravenous medications, can cause harm to patients, and therefore, they can only be performed by individuals who have been authorized to do so by a regulated health profession, such as nursing (*Nursing Act, 1991*).

College of Nurses Ontario

CNO Practice Standard

Scope of Practice [PDF]

CNO Fact Sheet

Legislation and Regulation: An Introduction to the Nursing Act, 1991 [PDF].

CNO

Understanding Your Scope of Practice FAQ



Watch: Understanding Your Nursing Scope of Practice

Video: “Understanding Your Nursing Scope of Practice: Essential Tips for Students” by Nurses Will Pass [4:14] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Questions to Ask

Ask these questions before performing any procedure or activity:

1. Do I have the authority?
2. Does my employer/practice setting support it?
3. Do I have the knowledge, skill and judgment?
4. Is it in the patient’s best interest?

(CNO, n.d.-d)

From Theory to Practice

A second-year student nurse is doing clinical placement at a nursing home. The nurse preceptor asks the student to discontinue the catheter of one of the residents. The student tells the preceptor they have only read about the procedure and watched a demonstration in the lab. The student nurse has never discontinued a catheter before and feels very anxious about doing something without an instructor present. The preceptor reminds the student that it is a very easy procedure, “you won’t hurt the resident,” and “we all have to do the first one at some point!” The preceptor quickly reminds the student about the equipment needed and what to do.

■ *What must the student do? What would you do following professional, ethical, and legal responsibilities of nursing practice?*

2.5 Privacy and Confidentiality



Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— College of Nurses of Ontario

Introduction

Nurses have ethical and legal responsibilities to maintain the confidentiality and privacy of client health information obtained while providing care. One way that nurses maintain boundaries and build nurse-client relationships based on trust is by respecting clients' rights around confidentiality and privacy.

Ontario's privacy legislation supports and extends the College of Nurses of Ontario's (CNO's) standards on nurses' accountabilities pertaining to clients' personal health information. This document provides an overview of Ontario's current legislation, clarifies nursing standards for confidentiality and privacy of personal health information, and replaces the *Confidentiality* practice guideline (#41045). It also updates the information on security and confidentiality of personal health information in the *Documentation, Revised 2008* practice standard (CNO, 2025b).

A. Personal Health Information Protection Act

The *Personal Health Information Protection Act, 2004* (PHIPA) governs health care information privacy in Ontario. Information privacy is defined as the client's right to control how his/her personal health information is collected, used and disclosed. PHIPA sets consistent rules for the management of personal health information and outlines the client's rights regarding his/her personal health information. This legislation balances a client's right to privacy with the need of individuals and organizations providing health care to access and share health information.

PHIPA permits the sharing of personal health information among health care team members to facilitate efficient and effective care. The health care team includes all those providing care to the client, regardless of whether they are employed by the same organization. PHIPA requires that personal health information be kept confidential and secure. Security refers to the processes and tools that ensure the confidentiality of information. When using computers, nurses should refer to the *Documentation, Revised 2008* practice standard (CNO, 2025).

B. Quality of Care Information Protection Act

The *Quality of Care Information Protection Act, 2016* (QOCIPA) is another piece of legislation for the health care sector. This Act provides broad protection to quality of care information produced by a health care facility or a health care entity, or for a governing or regulatory body. Its purpose is to promote open discussion of adverse events, peer review activities and quality of care information, while protecting this information from

being used in litigation or accessed by clients. This means that nurses' activities and records associated with the College's Quality Assurance Program cannot be used in legal proceedings (CNO, 2025).



Watch: On Confidentiality

Confidentiality in Nursing

Video: "Confidentiality in Nursing | NCLEX Ethical Principles Review | Patient Privac" by NCLEX [3:30] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Privacy and Confidentiality: An Overview (CNO)

Video: "Confidentiality and Privacy webcast" by The College of Nurses of Ontario (CNO) [10:44] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Privacy and Confidentiality: Case Studies (CNO)

Video: "CONFIDENTIALITY AND PRIVACY: CASE STUDIES" by The College of Nurses of Ontario (CNO) [9:37] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

A nurse on the Maternity floor receives a phone call about the delivery of one of the patients. The caller states that the patient is related to the hospital's Chief of Cardiology. The caller also states that they are the patient's mother and they are on their way to the hospital. The grandmother inquires and demands all the details about their grandchild's birth.

What must the nurse do? What would you do following professional, ethical, and legal responsibilities of nursing practice?

2.6 Boundaries

Professional Boundaries¹

A boundary in the nurse-client relationship is the point when the relationship changes from professional and therapeutic to unprofessional and personal. To help protect the therapeutic nurse-client relationship, it is the nurse's responsibility to establish and maintain professional boundaries, regardless of the client's actions or requests. Maintaining boundaries helps prevent the power imbalance from negatively affecting the client's care. There must be a clear distinction between a nurse's behaviour that prioritizes meeting the therapeutic needs of the client and behaviour that focuses on the personal needs of the nurse.

Nurses must consider the client's unique experience, including their culture, age, values, or experiences of trauma, when establishing and maintaining professional boundaries in the nurse-client relationship. This relationship exists on a continuum ranging from professional and appropriate behaviours to personal and inappropriate ones. Boundary violations can occur through under-involvement (for example, disinterest, neglect or abandonment) or over-involvement (for example, favouritism or spending time with a client after work). Regardless of the intent, a boundary violation may be considered professional misconduct.

Nurses must communicate the boundaries and limitations of the relationship, including providing clarification to the client when there is potential for uncertainty. For example, in a community setting, meeting a client for coffee as part of the care plan may be acceptable. But meeting a client socially for coffee, unrelated to care, would not be acceptable. Some practice settings require increased attention to ensure professional boundaries are maintained, for example, when care is provided in a client's home. The nurse is responsible for continually clarifying and reinforcing the boundaries of the therapeutic relationship.

Boundary Crossing

Competent and caring professionals can unintentionally cross boundaries. Boundary crossings may create role confusion, increase client vulnerability and lead to negative client outcomes. They can escalate when a nurse's actions exploit the relationship to meet their own personal needs at the expense of the client. Boundary crossings are less likely to escalate into more serious boundary violations if the nurse reflects on their actions, recognizes the boundary breach, and takes appropriate action to protect the client and re-establish appropriate boundaries. Examples of boundary crossings depend on the context and may include preferential attention to a particular client, socializing with the client or their family, or inappropriately sharing personal information. Additionally, nurses must not engage in any financial transactions unrelated to the provision of care with a client or the client's family. These may include financial or personal benefit to themselves or loss to the client, such as borrowing money from a client. All breaches of professional boundaries are unacceptable and may constitute professional misconduct.

Gifts

Nurses should avoid giving and accepting gifts, as that can blur boundaries and negatively impact the thera-

1. This section was reproduced from CNO's Professional Boundaries and Nurse-Client Relationship (2025).

peutic nurse-client relationship. Exchanging gifts can also introduce risks, such as unclear boundaries, conflicts of interest, and an impact on clinical judgment and objectivity. These risks increase as the value of the gift increases and as the gift becomes more personal. However, there may be situations in which refusing to accept a small gift could offend the client (for example, an expected practice in some cultures) and cause harm to the therapeutic relationship. Nurses must ensure that if they accept a gift, it does not change the dynamics of the therapeutic relationship and the client does not expect anything in return, including special treatment. Nurses should also make sure accepting a gift doesn't negatively impact other clients or other members of the health care team. If a nurse is unsure whether it is appropriate to accept a gift, they should consider the monetary value, the perception that may be caused by accepting it and consult with their employer.

Professional Boundaries and Technology Use

The use of technology can create an additional layer of complexity when providing care and may either support or hinder maintaining boundaries in the therapeutic nurse-client relationship. Nurses must ensure, when they are using any form of electronic communication, to connect with clients, such as calls, virtual meetings, texts or emails, they remain professional and focused on client care. See CNO's Virtual Care guideline for guidance.

Technology use that shifts toward informal, social or personal communication may blur boundaries and jeopardize the therapeutic nurse-client relationship. For example, nurses must refrain from connecting with clients, following clients, or accepting friend requests from clients on their personal *social media* accounts. Additional considerations will be needed if there is a pre-existing personal relationship.

Providing nursing care to family and friends Nurses should avoid providing nursing care for family and friends, except in limited circumstances when they are unable to transfer care. For example, in small communities, nurses may be required to provide care to their family members or friends if there are no other health care providers available. In circumstances in which nurses are required to provide care to family or friends, nurses should acknowledge their dual roles, set clear boundaries to clarify their personal and professional roles, and transfer care to another health care provider whenever possible.

Accountabilities

To maintain professional boundaries, nurses:

- ensure the focus of the therapeutic relationship is on the needs of the client and not on the personal needs of the nurse
- recognize when the boundaries of the therapeutic nurse-client relationship are at risk of being compromised and take action to protect them
- are responsible to clarify and reinforce the boundaries of the therapeutic relationship, particularly in instances when clients' requests are beyond the limits of the relationship
- recognize there may be an increased need for vigilance in maintaining professionalism and boundaries in certain practice settings
- refrain from participating in financial transactions with the client or the client's family outside the provision of care

- limit the sharing of their personal information with clients (including personal contact information). If deemed necessary, document and inform the health care team as needed, and share only information that supports the therapeutic relationship.
- refrain from entering friendships or personal relationships with clients
- do not interfere with the client's personal relationships, including not engaging in personal or sexual relationships with the client's family member that may impact the therapeutic nurse-client relationship
- document any approach or activity that is part of the client's care plan, including those that could be misinterpreted as crossing a boundary
- refrain from accepting and giving gifts, unless it would cause harm to the therapeutic nurse-client relationship. Gifts should never have more than a token monetary value.
- do not solicit gifts
- refrain from using electronic communication and social media with clients for personal use
- avoid providing nursing care to family or friends and whenever possible, transfer care to another health care provider
- consult with a colleague or manager in any situation in which there are concerns about professional boundaries, and report concerns of boundary violations to the appropriate person

(CNO, 2025).



Watch: On Professional Boundaries

Professional Boundaries and Nurse-Client Relationships Practice Standard

Video: "Professional Boundaries and Nurse-Client Relationships practice standard Webinar Recording" by The College of Nurses of Ontario (CNO) [8:58] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Professional Boundaries in Nursing

Video: "Professional Boundaries in Nursing- Full Version" by NCSBN [9:13] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Reflective Questions

See the *Reflection* section from CNO for the questions and exercises regarding professional boundaries to consider with your classmates

Nurses and student nurses must always uphold their professional, ethical, and legal responsibilities in any setting. They must always respect and follow the standards of practice. In addition, it's also important to note that

professionalism extends to the online environment as well. Therefore, nurses and student nurses must be careful and adhere to the professional, ethical, and legal responsibilities applicable to online professional behaviour.



Watch: On Professionalism

Professionalism in the Workplace

Video: “Professionalism in the Workplace with Trish Geerlinks” by Humber Faculty of Health & Life Sciences [1:58] is licensed under the Standard YouTube License. Transcript and closed captions available on YouTube.

Professionalism in the Workplace with Mary McAllister

Video: “Professionalism in the Workplace with Mary McAllister” by Humber Faculty of Health & Life Sciences [2:17] is licensed under the Standard YouTube License. Transcript and closed captions available on YouTube.

Social Media: Reflect Before You Post

CNO: Reflect Before You Post – Posting with purpose on Social Media

RNAO: Reflect Before You Post – The Regulatory Reality for Nurses Online

Please look carefully at the sites from CNO and RNAO above regarding their guidance on social media use for nurses. Social media is part of everyday life. Therefore, nurses and student nurses must be aware that their online presence can reflect their professional identity. Thus, it is very important to pause and reflect before posting. CNO encourages all nurses to reflect on how their posts may be perceived by patients, colleagues, and the public. Postings from personal accounts should not touch on sensitive professional nursing topics and/or appear to conflict with professional standards of practice. Any time you identify yourself as a nurse (or a student nurse), you must uphold professional, ethical, legal, and organizational (including educational institutions) responsibilities.

The CNO provides some guidance regarding postings on social media use that include:

Keep it respectful. Avoid content that could be seen as discriminatory, misleading or culturally unsafe

Protect confidentiality. Never share patient details, even indirectly

Know your boundaries. Don’t engage with patients on social platforms

Stay informed. Review the Code of Conduct, the guidance document Social Media Use: Common Expectations for Nurses and CNO’s community guidelines for best practices

Social media can be a powerful tool for connection and advocacy. By posting with intention and professionalism, you help maintain public trust and uphold the values of nursing (CNO, 2026b).

Virtual Practice Guidelines (PDF)

The purpose of this practice guideline is to offer nurses considerations that are important when providing care to clients virtually.

From Theory to Practice

One of the clients in a community palliative care nurse's roster has passed away. The client named the nurse the sole beneficiary in the will. The nurse and the palliative team provided nursing care to the client for over 7 years. The client's lawyer has contacted the nurse regarding the will.

What must the community palliative care nurse do? What would you do following professional, ethical, and legal responsibilities of nursing practice?

2.7 Chapter Summary



Key Takeaways

Professional, ethical, and legal responsibilities ensure the public receives safe, ethical, competent, caring and compassionate nursing care. Nurses have the duty to practice in ways that honour the patient's dignity and respect their humanity, regardless of who they are and their way of life. It is essential for student nurses and professional nurses to know, understand, and integrate professional, ethical, and legal principles governing their practice to ensure the well-being and safety of the people, families, communities, and organizations they serve. Safe, competent, ethical, caring and compassionate individual nursing practice contributes to the growth of nursing as a profession, art, and science.



Knowledge Check

Quiz Text Description

1. MultiChoice Activity

Canadian nursing practice is regulated by

- a. The Regulated Health Professionals Act
- b. Provincial or territorial nursing organizations
- c. The Nursing Act
- d. The Canadian Nursing Association

2. MultiChoice Activity

The regulatory nursing body for professional nursing practice in Ontario is the

- a. CNO
- b. ICN
- c. CNA
- d. RNAO

3. MultiChoice Activity

Standards of nursing practice in Ontario include all the following except for

- a. Consent
- b. Documentation
- c. Code of Conduct
- d. Medication

4. MultiChoice Activity

The Code of Conduct for nurses in Ontario includes the principle of

- a. Trust
- b. Dignity
- c. Empathy
- d. Immediacy

5. MultiChoice Activity

According to the CNA's Code of Ethics (2025), nurses maintain integrity and accountability in nursing practice by

- a. respecting the inherent dignity and autonomy of people

- b. maintaining the wellbeing of people at the center of their relationships
- c. acting with integrity, honesty, responsibility, trustworthiness and accountability
- d. considering the social determinants of health to influence the health of people

6. MultiChoice Activity

The CNO's "Experiences of Discrimination in Nursing Practice: A Focus on Racism" report states that racialized nurses are

- a. well respected by patients and never face any type of discrimination
- b. extremely overrepresented in positions of leadership in the health care system
- c. well supported by peers and management throughout their nursing career
- d. disproportionately referred to the regulatory body for disciplinary proceedings

7. MultiChoice Activity

RNs are authorized to perform the following controlled acts except for

- a. dispensing a drug
- b. performing a prescribed procedure below the dermis
- c. communicating a diagnosis
- d. administering a substance by injection or inhalation

8. MultiChoice Activity

According to the legislation, the personal health information collected by the health care team belongs to

- a. the client
- b. the team
- c. the unit
- d. the institution

9. MultiChoice Activity

Following the CNO's Professional Boundaries and Nurse-Client Relationship Practice Standard (2025), emotional abuse includes but is not limited to

- a. discrimination
- b. isolation
- c. using force
- d. ignoring

10. MultiChoice Activity

When making a posting on social media in a professional capacity, a nurse must consider

- a. What are the consequences for clients, colleagues, and themselves?
- b. How might posting affect their nursing practice?
- c. Who will see the post?
- d. All of the above

Solution:

1. b. Provincial or territorial nursing organizations
2. a. CNO
3. a. Consent
4. b. Dignity
5. c. acting with integrity, honesty, responsibility, trustworthiness and accountability
6. d. disproportionately referred to the regulatory body for disciplinary proceedings
7. c. communicating a diagnosis
8. a. the client
9. a. discrimination
10. d. All of the above



For Further Reflection

Video: “Growing calls to fight racism in healthcare” by CityNews [2:46] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

What would you do and say as the nurse?



TJ's Case Study Analysis

Review the scenario

Key Points

- Remind TJ you are their nurse and therefore you have a professional therapeutic nurse-client relationship. You are glad they trust you because that is very important to you. Their trust is necessary to establish and maintain a professional therapeutic relationship
- Clearly state you cannot become friends because that will cross and violate your professional, therapeutic, and organizational boundaries
- Following professional, ethical, legal and institutional guidelines, you cannot give TJ your number and follow/friend them on social media
- If TJ needs to talk to anyone, and/or access support services, tell them you will investigate and provide them with referrals to counselling, social work, etc., as needed
- Remind TJ that your professional relationship will end when they are discharged
- Check with TJ that they have a support system in place

CHAPTER 3: KNOWLEDGE, CRITICAL THINKING, AND HOLISTIC HEALTH ASSESSMENT

Chapter Overview



- 3.0 Learning Objectives
- 3.1 Chapter Introduction
- 3.2 Nursing Theory and Personal Philosophy of Nursing Practice
- 3.3 Patterns of Knowing (POK)
- 3.4 Nursing Process (ADPIE)
- 3.5 Thinking Like a Nurse: Critical Thinking and Clinical Judgement
- 3.6 Holistic Assessment in Nursing Practice
- 3.7 Chapter Summary

3.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Identify different types of knowledge that nurses must acquire to practice in a safe, ethical, competent, caring, and compassionate manner.
2. Apply patterns of knowing (POK) to different case scenarios to prepare and organize nursing care.
3. Describe each phase of the nursing process (ADPIE) and practice using it with different situations.
4. Discuss the importance of a holistic health assessment and demonstrate its application to a case scenario.
5. Practice using ASEPTIC when conducting a general survey.

3.1 Chapter Introduction

Nursing is a science and an art. Nurses must provide care that relies on evidence-based practices to prevent causing harm and improve/promote health and wellness (Agure et al., 2024). Professional nursing requires that nurses integrate various types of knowledge, including therapeutic, relational, humanistic, holistic, strength-based, anti-racist, trauma-informed, and patient-centred approaches into their practice to understand what is important to the people they care for, about, and with. Nurses are interested in phenomena that are conducive to the health and wellness of individuals. Therefore, knowledge from other fields or specialties, life in general, and working with interdisciplinary colleagues can be very helpful to the nurse when organizing and providing nursing care. Nurses cannot meet their professional, ethical, and legal responsibilities or be truly successful in providing care to people unless they understand the uniqueness of the individuals they serve (RNAO, 2025).

Registered Nurse (RN) Defined

The Canadian Nurses Association (2015) defines registered nurses (RNs) as self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities and populations to achieve their optimal levels of health.

At all stages of life, in situations of health, illness, injury and disability, RNs deliver direct health-care services, coordinate care, and support clients in managing their own health. RNs contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research, and policy (CNA, 2015).



What would you do and say as the nurse?

The public health nurse visits one of the schools in their caseload and finds a teacher's request to meet a 7-year-old dealing with depression following the parents' divorce. The child has also been experiencing bullying at school, and the teachers are worried.

3.2 Nursing Theory and Personal Philosophy of Nursing Practice

Nursing theories and frameworks explain, guide, and help to expand the science of nursing (McMaster University Health Sciences Library, 2026). Nursing theory defines important concepts, definitions, and assumptions that guide nursing practice, education, and research by defining what nursing is, what nurses do, and why they do it (Wayne, 2026).

There are many types of nursing theories. Each nursing theory focuses on an approach to providing nursing care grounded in the nursing theorist's philosophy and research findings to ensure safe, effective, and competent nursing practices ("Nursing Theory," 2017). Although each nursing theory is composed of different assumptions, concepts, and philosophies, all nursing theories focus on fundamental concepts known as the metaparadigm of nursing science. These concepts include the person, nursing, environment, and health (SimpleNursing, 2023).



Watch: Nursing Meta Paradigms Simply Explained

Video: "Nursing Meta Paradigms Simply Explained: Person, Environment, Health, and Nursing" by SimpleNursing [4:25] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

A personal philosophy of nursing helps you identify the foundational values and theories of your nursing practice. A personal philosophy outlines the values, ethics, beliefs, and individual motivation for being part of the nursing profession (University of St. Augustine for Health Sciences, 2024a). Your personal philosophy of nursing practice includes your views about professionalism, which is necessary to provide high-quality care while upholding the values of accountability, respect, and integrity (2024b).

Nurses must be able to apply different types of knowledge, including nursing theory, into their practice. To be able to provide safe, competent, ethical, caring, and compassionate care while meeting professional, ethical, and legal responsibilities, nurses must acquire knowledge.

From Theory to Practice

What is important to you about nursing practice? What will you focus on when providing nursing care to patients? How will you demonstrate professionalism while providing safe, competent, ethical, caring, and compassionate nursing care?

Consider your reasons for becoming an RN. How might your personal values, beliefs, morals, and ethics impact your professional nursing practice?

Begin to formulate and articulate your personal philosophy of nursing practice.

3.3 Patterns of Knowing (POK)



Watch: Patterns of Knowledge

Video: “Barbara Carper’s patterns of nursing knowledge” by Lynn Jakobs [6:30] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Carper’s (1978) framework explains the four fundamental types of knowledge that nurses require to provide holistic care to people (Carper, 1978). These include *empirical*, *ethical*, *aesthetic*, and *personal knowing*, which the nurse must apply in their practice with each patient they meet, regardless of the context where care is provided and the patient (Lindell & Chinn, 2022).



Watch: On Knowledge

Empirical Knowledge

Empirical Knowledge relates to the science of nursing practice. It includes all the technical knowledge required to practice nursing.

Video: “Empirical Knowing” by Danielle Weber [2:18] is licensed under the Standard YouTube License .*Transcript and closed captions available on YouTube.*

Ethical Knowledge

Ethical Knowledge is the moral component of nursing. It includes the values and beliefs of nursing as a profession, the nursing Code of Ethics, and the Code of Conduct. Ethical theories and frameworks, as well as ethical principles, which assist in providing ethical nursing care, are also an integral part of ethical knowing in nursing.

Video: “Ethical Knowing” by Danielle Weber [0:49] is licensed under the Standard YouTube License .*Transcript and closed captions available on YouTube.*

Aesthetic Knowledge

Aesthetic knowledge refers to the art of nursing practice and how nurses interact with patients in unique ways that meet professional, ethical, and legal responsibilities. Nurses provide care to people facing different challenges. When nurses apply aesthetic knowledge, they treat each patient in a way that is safe, competent, ethical, caring, and compassionate that fits each patient’s individual needs.

Video: “Aesthetic Knowing” by Danielle Weber [2:50] is licensed under the Standard YouTube License .*Transcript and closed captions available on YouTube.*

Personal Knowledge

Personal Knowledge consists of knowing the self and knowing the patient. Knowing the self relates to the nurse’s awareness of personal values, beliefs, and biases and their impact on the ability to provide safe, competent, ethical, caring, and compassionate care. Nurses must always be aware of their individual impact and accountability when they assume a professional nursing role. Personal Knowledge also includes the knowledge that the nurse must research about their patients. The nurse must acquire information about the patient’s medical condition, health, illness, support systems, finances, and everything that is important and conducive to people’s quality of life and/or diminished well-being.

Video: “Personal Knowing NURS170” by Sheri Beasley [1:57] is licensed under the Standard YouTube License.*Transcript and closed captions available on YouTube.*

Chinn and Kramer (2013) expanded Carper's framework to include emancipatory knowing. Nurses recognize the interdependence of humans, health, and the environment as well as the critical impact of the social determinants on the health of individuals, families, communities, and the world. In light of global awareness of inequality and injustice, nurses must question the status quo and engage in advocacy to drive change and improve the quality of life of vulnerable populations.

When nurses apply emancipatory knowing in their practice, they specifically question:

- Who benefits?
- What is wrong with this picture?
- What are the barriers to freedom?
- What changes are needed?

(Lindell & Chinn, 2024).



Watch: Emancipatory-Sociopolitical Knowing

Video: "Sociopolitical Approach to Nursing" by Ashley Condon [3:20] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Patricia Munhall's concept of "unknowing" (1993) in nursing encompasses openness, humility, and wonder. When nurses acknowledge what they do not know, they can ignore preconceived notions so they can genuinely listen to better understand, with empathy, the unique lived experiences of patients.



Clinical Example: The Art of Unknowing

Imagine an elderly patient admitted for a severe diabetic foot ulcer.

The Empirical (Knowing) Approach

A nurse knows how to dress the wound, check blood glucose, and administer insulin based on scientific evidence.

The Munhall “Unknowing” Approach

Rather than approaching the patient solely as a textbook diabetic case, the nurse recognizes that they do not know what this illness means to this specific individual.

The Action

The nurse sits with the patient, unburdens themselves of preconceived assumptions about “non-compliant diabetics,” and asks open-ended questions about the patient’s daily routine, fears, and cultural beliefs. By admitting, “I do not know your subjective world,” the nurse creates a condition of openness. This allows the patient to reveal their true reality—perhaps they were skipping doses because the medication is too expensive, leading to a much deeper, more empathetic, and effective care plan.

From Theory to Practice

You have been assigned to care for a patient labelled by the staff as uncooperative and difficult. The night nurses tell you that they do not like caring for this patient. They mention that the patient is from a different culture with unfamiliar customs and discuss their negative feelings about this patient. During the report, you are told that the patient has self-inflicted injuries. You are also cautioned to be careful with potential violent behavior.

As you enter the patient's room for the first time, you notice a frightened and uncomfortable look on the patient's face. During the report, you were told that the patient has a neck injury and can only communicate through the blinking of the eyes. The hands are restrained because the patient is always pulling their tubes and equipment, which makes the nurses' work more difficult.

As you stand at the door, you realize the room is cool. There is a sheet on the bed that is meant to cover the patient's naked body.

What must the nurse do? What would you do following professional, ethical, and legal responsibilities of nursing practice?

Apply each POK to help you analyze and critically think about this situation. Describe and justify your course of action, including the way in which you might demonstrate your professionalism while providing safe, competent, ethical, caring, and compassionate nursing care to the patient.

3.4 Nursing Process (ADPIE)

The nursing process is a foundational scientific framework that guides nursing practice. It is a systematic approach that integrates fundamental principles in nursing, including critical thinking, client-centred care, goal-oriented tasks, evidence-based practice, and holistic health (Toney-Butler & Thayer, 2023).

The nursing process consists of five steps: *assessment (A)*, *diagnosis (D)*, *planning (P)*, *implementation (I)*, and *evaluation (E)*. It applies the steps in a continuous, cyclical process, depending on the patient's health status, to ensure they provide quality, compassionate, holistic, patient-centred care (Waters, 2025). Nurses around the world use the framework to guide and organize their nursing care. In some countries, the framework has been adapted with additional components. For example, the American Nurses Association uses **ADOPIE**, which includes Assessment, Diagnosis, Outcomes Identification, Planning, Implementation, and Evaluation (ANA, n.d.).

Regardless of the number of steps, when a nurse applies **ADPIE** to organize their care, they are expected to engage in the:

Step #1 – Assessment

A – Assessment of the patient: the nurse must systematically collect subjective (what the patient says) and objective (measurable information like vital signs) data. Nurses must apply their knowledge to help them assess the patient, determine what is happening, and decide what they must do to help.

Step #2 – Diagnosis

D – Diagnosis of the main issues/challenges/concerns/priorities for the patient: the nurse must analyze the collected data to identify the patient's actual or potential health problems, risks, and responses to illness. A nursing diagnosis is not the same as a medical diagnosis (Appendix A: Sample NANDA-I Diagnoses). Nursing diagnoses fall under the International Nursing Knowledge Association (INKA), formerly known as North American Nursing Diagnoses Association International (NANDA-I) classification (INKA, n.d.).

Step #3 – Planning

P – Planning of the nursing care that must be provided: after the nursing diagnosis/main issue(s)/challenges/health problems/priorities have been identified, the nurse must decide what to do for the patient. Following professional-legal-organizational responsibilities, nurses set measurable, patient-centred goals, and determine the specific nursing interventions that will aid in resolving the identified nursing diagnoses/main issue(s)/challenges/health problems/priorities. Nursing care is established using care plans and other documentation standards followed by health care organizations.

Step #4 – Implementation

I – Implementation of the required nursing care: nurses apply their scope of practice and organizational responsibilities to carry out the interventions set into the patient's plan of care.

Step #5 – Evaluation

E – Evaluation of the nursing care provided: the nursing care provided and specific nursing interventions must be continuously monitored to check whether it is effective or ineffective in meeting the patient's health needs. Nurses must document the patient's responses to the care provided following professional, ethical, legal, and organizational responsibilities of professional nursing practice. The nurse must assess and determine the patient's progress in meeting the goals set in the plan of care to determine if the nursing care plan was successful, ineffective, or needs modification.



Watch: The Five-Step Nursing Process Explained

Video: "The Five Step Nursing Process Explained | Intro to ADPIE | Lecturio Nursing" by Lecturio Nursing [5:03] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Patient Scenario: Using the Nursing Process

Review the patient scenario in the box below to see how a nurse uses the nursing process while providing patient care.

A hospitalized patient has a prescription to receive Lasix 80mg IV every morning for a medical diagnosis of heart failure. During the morning assessment, the nurse notes that the patient has a blood pressure of 98/60, heart rate of 100, respirations of 18, and a temperature of 98.7F. The nurse reviews the medical record for the patient's vital signs baseline and observes that the blood pressure trend is around 110/70 and the heart rate in the 80s. The nurse recognizes these cues form a pattern related to fluid imbalance and hypothesizes that the patient may be dehydrated. The nurse gathers additional information and notes that the patient's weight has decreased by 4 pounds since yesterday. The nurse talks with the patient and validates the hypothesis when the patient reports that their mouth feels like cotton and they feel light-headed. By using critical thinking and clinical judgment, the nurse diagnoses the patient with the nursing diagnosis Fluid Volume Deficit and establishes outcomes for reestablishing fluid balance. The nurse withholds the administration of IV Lasix and contacts the health care provider to discuss the patient's current fluid status. After contacting the provider, the nurse initiates additional nursing interventions to promote oral intake and closely monitor hydration status. By the end of the shift, the nurse evaluates the patient's status and determines that fluid balance has been restored.



Image: "Patient Image in LTC.JPG" by ARISE project, CC BY 4.0.

Explain how the nurse used the nursing process?

In the patient scenario, the nurse uses clinical judgement and does not just follow the physician's orders to administer the medication (Lasix) as scheduled. The nurse assesses the patient, recognizes cues, creates a generalization and hypothesis regarding the fluid status, plans and implements nursing interventions, and evaluates the outcome. Additionally, the nurse promotes patient safety by contacting the physician before administering a medication that could cause harm to the patient at this time."

From Theory to Practice

A first-year student nurse is preparing for their weekly Holistic Assessment lab practice. The assigned case scenario is about a 15-year-old dealing with anorexia and body dysmorphia. The patient is also unable to let their parents know they are gay.

What must the student nurse do? What would you do following professional, ethical, and legal responsibilities of nursing practice?

- Apply each POK to help you analyze and critically think about this situation. Describe and justify your course of action, including the way in which you might demonstrate your professionalism while providing safe, competent, ethical, caring, and compassionate nursing care to the patient.
- Apply each step of ADPIE to help you analyze, critically think about this situation, and organize what you would do when you get to the lab and meet the standardized patient (SP).

The *patient scenario section* has been adapted from “4.1. Nursing process Introduction” in Nursing Fundamentals, edited by Kimberly Ernstmeyer and Elizabeth Christman, which is licensed under a Creative Commons Attribution 4.0 International License.

3.5 Thinking Like a Nurse: Critical Thinking and Clinical Judgement

Nurses make decisions while providing patient care by using critical thinking and clinical reasoning. Critical thinking is a broad term used in nursing that encompasses “reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow” (Klenke-Borgmann et al., 2020). Using critical thinking means that nurses take extra steps to maintain patient safety and don’t just “follow orders.” It also means that the accuracy of patient information is validated and that plans for patient care are based on their needs, current clinical practice, and research.

“Critical thinkers” possess certain attitudes that foster rational thinking. These attitudes are as follows:

- Independence of thought: Thinking on your own
- Fair-mindedness: Treating every viewpoint in an unbiased, unprejudiced way
- Insight into egocentricity and sociocentricity: Thinking of the greater good and not just thinking of your-self. Knowing when you are thinking of yourself (egocentricity) and when you are thinking or acting for the greater good (sociocentricity)
- Intellectual humility: Recognizing your intellectual limitations and abilities
- Nonjudgmental: Using professional ethical standards and not basing your judgments on your own personal or moral standards
- Integrity: Being honest and demonstrating strong moral principles
- Perseverance: Persisting in doing something despite it being difficult
- Confidence: Believing in yourself to complete a task or activity
- Interest in exploring thoughts and feelings: Wanting to explore different ways of knowing
- Curiosity: Asking “why” and wanting to know more

Clinical reasoning is defined as “A complex cognitive process that uses formal and informal thinking strategies to gather and analyze patient information, evaluate the significance of this information, and weigh alternative actions”(Klenke-Borgmann et al., 2020). To make sound judgments about patient care, nurses must generate alternatives, weigh them against the evidence, and choose the best course of action. The ability to clinically reason develops over time and is based on knowledge and experience (Powers et al., 2020).

3.4.1 Inductive, Deductive Reasoning, and Clinical Judgement

Inductive and deductive reasoning are important critical thinking skills. They help the nurse use clinical judgement when implementing the nursing process.

Inductive Reasoning

Inductive reasoning involves noticing cues, making generalizations, and creating hypotheses. Cues are data that fall outside of expected findings that give the nurse a hint or indication of a patient’s potential problem or condition. The nurse organizes these cues into patterns and creates a generalization. A generalization is a judgment formed from a set of facts, cues, and observations, similar to gathering pieces of a jigsaw puzzle into patterns until the whole picture becomes clearer. Based on generalizations derived from data patterns, the nurse develops a hypothesis about a patient’s problem. A hypothesis is a proposed explanation for a situation.

It attempts to explain the “why” behind the problem. If a “why” is identified, then a solution can begin to be explored.

No one can draw conclusions without first noticing cues. Paying close attention to a patient, the environment, and interactions with family members is critical for inductive reasoning. As you work to improve your inductive reasoning, begin by first noticing details about the things around you. A nurse is like a detective, looking for cues and mindful of what they hear, feel, smell, and see. Nurses need strong inductive reasoning and the ability to take action quickly, especially in emergency situations. They can see how certain objects or events form a pattern (i.e., generalization) that indicates a common problem (i.e., hypothesis).



Example: Assessing a Surgical Incision Site

A nurse assesses a patient and finds the surgical incision site is red, warm, and tender to the touch. The nurse recognizes these cues form a pattern of signs of infection and creates a hypothesis (nursing diagnosis) that the incision has become infected. The physician is notified of the patient’s change in condition, and a new prescription is received for an antibiotic. This is an example of the use of inductive reasoning in nursing practice.

Deductive Reasoning

Deductive reasoning is another type of critical thinking that is referred to as “top-down thinking.” Deductive reasoning relies on using general standards or rules to create a strategy. In Canada, nurses use standards of practice and guidelines, as well as professional, ethical, legal and organizational responsibilities to make decisions about patient care and solve problems.



Example: Implementing Interventions for a Quiet Zone Policy

Based on research findings, hospital leaders determine that patients recover more quickly if they receive adequate rest. The hospital creates a policy for quiet zones at night by initiating no overhead paging, promoting low-speaking voices by staff, and reducing lighting in the hallways. The nurse further implements this policy by organizing care for patients that promotes periods of uninterrupted rest at night. This is an example of deductive thinking because the intervention is applied to all patients to prevent any problems with sleeping due to the clinical area environment.

Clinical judgment is the result of critical thinking and clinical reasoning using inductive and deductive reasoning. In the United States, clinical judgment is defined by the National Council of State Boards of Nursing (NCSBN) as “The observed outcome of critical thinking and decision-making. It uses nursing knowledge to

observe and assess presenting situations, identify a prioritized patient concern, and generate the best possible evidence-based solutions in order to deliver safe patient care” (NCSBN, n.d.). The NCSBN administers the national licensure exam (NCLEX) that measures nursing clinical judgment and decision-making ability of prospective entry-level nurses to ensure safe and competent nursing care by licensed nurses.

The science and art of nursing practice require that nurses provide care that meets high-quality standards. Nurses must also meet professional, ethical, and legal responsibilities and establish a therapeutic nurse-client relationship to assess and attempt to meet client needs. Regardless of the context, nurses must provide care that supports evidence-based practice.

Evidence-based practice (EBP) is defined by the American Nurses Association (ANA) as, “A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health care consumer’s history and condition, as well as health care resources; and patient, family, group, community, and population preferences and values”(ANA, 2021).

Evidence-Based Practice in Nursing

Improving Patient Outcomes



Watch: What Is Critical Thinking Vs Clinical Judgment In Nursing?

Video: “What Is Critical Thinking Vs Clinical Judgment In Nursing? – Clinical Career Path” by Clinical Career Path [3:16] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

3.4.2 Development of Clinical Judgement

Student nurses and newly graduated nurses develop clinical judgement while learning to think like a nurse by applying the nursing process to determine what is happening to patients and how to best help them. Clinical judgement is critical to provide safe, ethical, competent, caring, and compassionate nursing care. Clinical judgement is essential to understand, analyze, and problem solve effectively while meeting professional, ethical, legal, and organizational responsibilities.

There are various frameworks, approaches, or methods to help novice nurses develop clinical judgment while applying critical thinking. Nursing theory guides practice and can help to develop a personal nursing philosophy of practice, which promotes clinical judgment. Knowledge in general, including the different patterns of knowing in nursing, is also essential to help the nurse develop experience and confidence in dealing with possible health challenges that patients can experience.

According to Tanner (2006), clinical judgment refers to the nurse’s interpretation of a patient’s concerns or health challenges and/or the decision to act by providing nursing care. Clinical judgement impacts the safety and quality of care and involves four aspects that include noticing, interpreting, responding, and reflecting (Nevada State University, 2024).

Caputi (2022) expands Tanner's model by stating that the development of clinical reasoning or judgement is the core of nursing education. Clinical reasoning or judgment allows nursing students to become self-directed thinkers who can make effective patient-centred health care decisions. Furthermore, effective clinical reasoning or judgement is crucial for preserving nursing care standards that lead to good patient outcomes. The Caputi's Method for Learning Clinical Judgment (2022) includes five steps: *getting information; making meaning of the information; determining actions to take; taking action; and evaluating outcomes and your thinking* (Caputi, 2022).

The Gillespie and Petersen's Situated Clinical-Decision Making Framework (2010) is a tool that can help novice and student nurses in making decisions about patient care. The framework can be used to reflect on decision-making processes and outcomes. It can assist new nurses to understand the nature of decision-making in nursing and foster the development of their knowledge, skills, and confidence as nurses. The tool consists of a multi-layered model composed of four main dimensions that include *context, foundational knowledge, decision-making, and thinking processes* (Gillespie, 2010).

Context:

Acknowledges the multi-layered social, cultural, political, and economic environments in which nursing care is delivered.

Foundational Knowledge:

The blend of theoretical knowledge, past experiences, and professional standards of care that the nurse brings to the situation. There are five types of foundational knowledge that the nurse must acquire, which include knowing the profession, the self, the case, the patient/client, and the person embodied in the patient/client.

Decision-Making Processes:

The actual strategies and choices utilized by the nurse to assess the patient and intervene.

Thinking Processes:

The cognitive skills, such as critical thinking, clinical reasoning, and reflection, that tie knowledge and context together.

From Theory to Practice

You are scheduled to give a 45-year-old patient their 8 am blood pressure medication. The night nurse stated during report that the patient's blood pressure at 5 am was 105/70.

What would you do?

- Apply each POK to help you analyze and critically think about this situation. Describe and justify your course of action, including the way in which you might demonstrate your professionalism while providing safe, competent, ethical, caring, and compassionate nursing care to the patient.
- Apply each step of ADPIE to help you analyze, critically think about the situation, and organize what you would do.
- Apply the steps of Tanner's clinical judgment model, Caputi's method for learning clinical judgment, or Gillespie and Petersen's situated clinical-decision making framework to help you decide what you can do for the patient while meeting professional, ethical, legal, and organizational responsibilities of nursing practice.

This section has been adapted, in part, from "4.1. Nursing process Introduction" in *Nursing Fundamentals*, edited by Kimberly Ernstmeier and Elizabeth Christman, which is licensed under a Creative Commons Attribution 4.0 International License. *Modifications: Revised and added content to adapt to Canadian nursing practice.*

3.6 Holistic Assessment in Nursing Practice

In a supportive and nonjudgmental manner, nurses assess all the factors in a person's life that affect wellness, illness, death, and quality of life. Such factors are commonly understood to be social determinants of health (Public Health Agency of Canada [PHAC], 2024). A goal of nursing practice has always been to focus on the whole person, including the mind, body, and spirit. A nurse's ability to view the individual, family, and community as an interconnected system supports disease prevention and encourages patients to take an active role in their health goals. The nurse uses therapeutic communication to establish a professional therapeutic nurse-client relationship. During a holistic health assessment, the nurse goes beyond only focusing on physical health and considers psychological, sociological, developmental, spiritual, and cultural aspects of the patient's life (Lamar University, 2025).

Depending on the framework used, the dimensions of a holistic health assessment include:

- **Physiological (Physical):** focuses on the anatomy and general functioning of the human body. The assessment includes vital signs, physical symptoms, as well as focused-systemic or head-to-toe assessments. It usually transitions from the least to the most invasive examination.
- **Psychological (Emotional):** includes mental health, cognitive function (thinking and problem-solving), life stressors, resilience, and coping.
- **Sociological-Cultural-Environmental:** explores the patient's support systems, living environment, socioeconomic status, impact of social determinants of health, and any potential barriers to healthcare access. An individual's culture includes specific values, beliefs, traditions, language, and communication. Culture can refer to ethnicity and/or a group of people, for example, the culture of student nurses.
- **Developmental:** includes the cognitive and psychosocial developmental stages of life. For example, a school-age child thinks and behaves differently from an adolescent, a young person, and an adult. Furthermore, there are different life goals that must be accomplished as people move through different life stages of human development (Sprouts, 2017).
- **Spiritual:** explores a person's general sense of meaning, purpose, and hope in life. The spiritual dimension can include religion, but this is not the only factor that contributes to spiritual health. A person may not follow a particular religion and be involved in spiritual practices.



Watch: The 6 Dimensions of Health

Video: “The 6 Dimensions of Health – SUMMARY OVERVIEW” by PErebootED (Ross Stewart) [6:07] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (PHAC, 2017). Given the impact of social determinants of health on a person's ability to attain wellness, be healthy, and maintain quality of life, a holistic health nursing assessment requires that the nurse understand what is important to the patient. Following professional, ethical, and legal nursing responsibilities, nurses are not required to agree with the patient's life choices but must assess and ensure that patients are competent and capable of making informed decisions (CNO, 2025c). Nurses are also responsible for assessing and ensuring that patient autonomy does not negatively impact the safety of the patient, people, and health care staff (Indridadottir & Nisco-Madden, 2025).



Watch: What is a Holistic Needs Assessment (HNA)?

Video: “
What is a Holistic Needs Assessment (HNA)? | Supporting people with cancer through personalised care
” by Macmillan Cancer Support [3:53] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

3.6.1 Holistic Nursing Practice

According to the Canadian Holistic Nurses Association (2020), Holistic Nursing Standards of Practice, holistic nursing is a way of being that recognizes and honours the mind-body-spirit-environment connection. It focuses on whole health and well-being for the nurse, client, and the planet. Holistic nursing recognizes the nurse as an instrument of healing or a facilitator in the healing process. A nurse who practices holistically must also demonstrate self-care, self-development, self-awareness, and self-healing practices in their life.



Watch: On Holistic Nursing

What is Holistic Nursing?

Video: “What is holistic nursing?” by HolisticNurses [1:15] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

What Is Holistic Nursing Practice?

Video: “What Is Holistic Nursing Practice” by AHNCC [2:02] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

3.6.2 Vulnerable Populations and Nursing Advocacy

Advocacy is a foundational and important philosophy of nursing practice. According to the Canadian Nurses Association (2026), advocacy involves engaging others, exercising your voice and mobilizing evidence to influence policy and practice. Advocacy requires that nurses speak out against inequity and inequality. It entails participating directly and indirectly in political processes and acknowledging the importance of evidence, power, and politics in advancing policy options (CNA, n.d.-b).

Nurses occupy an ideal position in health care whereby, through the practice of holistic health assessments, they can apply their understanding of social determinants of health to help them recognize the unique health risks to vulnerable populations. Nurses in general can assess, identify, and intervene to improve the health and health outcomes of individuals, families, and populations. Therefore, nurses have an important role in helping to advocate for the improvement of marginalized and vulnerable individuals in society.

Vulnerable Population Defined

A vulnerable population is a group of individuals who are at increased risk for health problems and health disparities (“Vulnerable Populations,” 2006). Health disparities are health differences linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who often experience greater obstacles to health based on individual characteristics, such as socioeconomic status, age, gender, culture, religion, mental illness, disability, sexual orientation, or gender identity (ODPHP, 2022).

Examples of vulnerable populations are:

- The very young and the very old
- Individuals with chronic illnesses, disabilities, or communication barriers
- Veterans
- Racial and ethnic minorities
- Individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ)
- Victims of human trafficking or sexual violence
- Individuals who are incarcerated and their family members
- Rural Canadians
- Migrant workers
- Individuals with chronic mental health disorders
- Homeless people (Joszt, 2018; “Vulnerable Populations,” 2006).

Individuals typically have less access to and use of health services, resulting in significant health disparities in life expectancy, morbidity, and mortality. They are also more likely to have one or more chronic physical and/or mental health illnesses(“Vulnerable Populations,” 2006). Advancing health equity for all members of our society is receiving increased emphasis as a central goal of public health. Health equity is defined by the U.S. Department of Health and Human Services as the “attainment of the highest level of health for all people” and that “achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of health and health care disparities.”(Liburd et al., 2020).

Read More

Examples of vulnerable populations and associated resources available to promote health equity and reduce health disparities are further described in the following resource.

3.6.3 General Survey (ASEPTIC)

A holistic nursing assessment begins with a general survey of the patient. When the nurse looks at the patient, using their “noticing” skills and critical thinking, they use their senses to begin collecting data about the patient. Doing so can help the nurse to become aware of any mental health challenges that the patient may be experiencing (Real, n.d.).

During a general survey, the nurse can use the ASEPTIC framework to collect data on any patient. ASEPTIC is a mnemonic used to organize the Mental State Examination (MSE), which provides quick information about a patient’s psychological and cognitive functioning at a given point in time (Abecassis et al., 2020). The ASEPTIC information is collected during the face-to-face interaction and can be combined with the health history interview, vital signs, and systemic assessment findings during a holistic health assessment.



ASEPTIC health assessment infographic

PsychDB (2024) describes that ASEPTIC includes the assessment of:

- **Appearance & Behaviour:** Observes the patient's apparent age, grooming, hygiene, eye contact, and physical mannerisms or abnormal movements.
- **Speech:** Evaluates the rate (e.g., pressured or slow), rhythm, volume, and quantity of the patient's words.
- **Emotion (Mood & Affect):** Distinguishes between mood (the patient's subjective emotional state) and affect (the observable, outward expression of that emotion).
- **Perception:** Assesses for abnormalities in sensory processing, such as auditory, visual, or tactile hallucinations.
- **Thought Content & Process:** Explores the flow of thoughts (e.g., flight of ideas, circumstantiality) and the actual content (e.g., delusions, obsessions, suicidal or homicidal ideation).
- **Insight & Judgement:** Determines whether the patient understands they have an illness/problem and whether they can make sound, safe decisions regarding their well-being.
- **Cognition:** Measures orientation to time, place, and person, as well as attention, concentration, and memory

Read More

Clerkship Tips: How to Administer a Mental Status Examination

How to Assess ASEPTC

Step #1: Appearance and Behaviour

Observe the patient's physical presentation and actions.

- **Appearance:** Note hygiene, grooming, clothing, apparent age versus stated age, and physical signs of self-harm or substance use.
- **Behaviour:** Observe psychomotor activity (e.g., restlessness, slowing), eye contact, facial expressions, and any involuntary movements or tics.

Step #2: Speech

Assess how the patient speaks, rather than just what they are saying.

- **Rate and Rhythm:** Is it rapid, pressured, hesitant, or slurred?
- **Volume and Tone:** Is it loud, soft, monotonous, or tremulous?
- **Quantity:** Is the speech excessive (pressured) or minimal (poverty of speech)?

Step #3: Emotion (Mood and Affect)

Assess both the patient's subjective emotional state and their objective expression.

- **Mood:** The internal, sustained feeling the patient describes (e.g., "depressed," "angry," "anxious").
- **Affect:** The outward, visible emotional expression observed by the clinician (e.g., flat, blunted, or euphoric).

Step #4: Perception

Check for sensory disturbances that are not based on external stimuli.

- **Hallucinations:** Ask if the patient sees, hears, smells, or feels things that aren't there.
- **Illusions / Alterations:** Note if they experience depersonalization (feeling detached from oneself) or derealization (feeling the world is unreal).

Step #5: Thought (Process and Content)

Assess how thoughts are formulated and what the patient is specifically focused on.

- **Thought Process:** Is the patient's speech logical, linear, or disconnected (e.g., flight of ideas, loose associations)?
- **Thought Content:** Assess for specific themes like delusions, obsessions, phobias, or suicidal/homicidal ideation.

Step #6: Insight and Judgment

Assess the patient's awareness of their condition and their ability to make safe, rational decisions.

- **Insight:** Does the patient recognize they have a mental health condition and understand the need for treatment?
- **Judgment:** Can the patient interpret situations appropriately and make safe choices?

Step #7: Cognition

Evaluate higher-level brain functions, which is crucial for ruling out delirium or dementia.

- **Orientation:** Does the patient know their name, the date, and their location?
- **Memory and Concentration:** Test this by asking them to recall three objects after 5 minutes or spell the word "WORLD" backward.



Watch: Mental Status Examination

Video: “Mental Status Examination – Psychiatric Mental Health Nursing Principles | @LevelUpRN” by Level Up RN [4:33] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Exercise: Applying ASEPTIC

Watch the video below and conduct a general survey applying ASEPTIC

Vignette 4: Introduction to a Mental Health Assessment

Video: “Vignette 4 – Introduction to a Mental Health Assessment” by YMH Boston [3:35] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

3.6.4 Interviewing in Nursing Practice

The nursing health history interview requires the nurse to establish a professional therapeutic relationship with the patient. The nurse must adapt each phase of the nurse-client relationship to the interview, apply core components, and use a patient-centred humanistic approach to help them critically think about how they can help the patient. The application of a strengths-based, trauma-informed, and anti-racist philosophy to the nurse’s practice is also helpful when conducting a holistic health assessment.

When conducting a health interview, regardless of the nursing specialty, the nurse must remember to include a pre-interaction, orientation, working, and termination phase, regardless of how long the interview lasts. To move through the different phases, the nurse applies therapeutic communication techniques to help them collect the necessary information from the patient. The nurse collects information (data) from the patient as they apply the nursing process and critically think about what they must do to help the patient.

Once the data collected is analyzed, the nurse formulates a nursing diagnosis and decides the key priorities they must address. The priorities are determined based on the nurse’s knowledge and expertise. The nurse organizes the care that must be provided following their knowledge about professional, ethical, legal, and organizational nursing responsibilities. Finally, the nursing interventions and care provided must be evaluated.

Following the evaluation, the nurse must reflect and learn about the experience, which contributes to the professional and personal growth of the nurse



Watch: On Therapeutic, Non-Therapeutic and Nonverbal Communication

Therapeutic Communication

Video: “

Nurse/Client Relationship, Therapeutic Communication -Psychiatric Mental Health Nursing |@LevelUpRN

” by Level Up RN [11:26] is licensed under the Standard YouTube License.*Transcript and closed captions available on YouTube.*

Non-Therapeutic Communication

Video: “Non-therapeutic Communication: Fundamentals | @LevelUpRN” by Level Up RN [1:15] is licensed under the Standard YouTube License.*Transcript and closed captions available on YouTube.*

Nonverbal Communication

Video: “What Your Body Language Says: Nonverbal Communication in Healthcare!” by nurselyf [3:10] is licensed under the Standard YouTube License.*Transcript and closed captions available on YouTube.*

Link to Learning

From Chapter 1: REVIEW: Strengths-Based Nursing Care (Gottlieb, 2013)

- See p302 SOLER
- See p304-307 Interviewing
- See p308-311 Nurse Behaviours that can Derail Clinical Conversations and Repair Methods

From Theory to Practice

A 16-year-old has come to the clinic for a physical assessment. They also express concerns regarding their sexual activity. Consider how you would address the concerns during a holistic health interview, using therapeutic communication techniques and observing the professional, ethical, and legal responsibilities of nursing practice.

Watch the video below to consider possible ways of conducting the interview.

Video: "Vignette 2 – Asking about Sexual Activity in a Preventive Services Visit" by YMH Boston [2:42]

The *Vulnerable Population* section was adapted from "17.2 Vulnerable Populations" in *Nursing: Mental Health and Community Concepts* Copyright © by Chippewa Valley Technical College, which is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

OpenAI. (2026). ASEPTIC health assessment infographic [AI-generated image]. ChatGPT. <https://chat.openai.com/>
Prompt

Create a simple graphic for a nursing communication textbook that includes the following information: "ASPECT: Physical, Emotional, Social, Spiritual, Cultural, Environmental." Use the colour theming for the textbook.

3.7 Chapter Summary



Key Takeaways

Nurses are responsible for acquiring the knowledge needed to provide safe, competent, ethical, caring, and compassionate care. Patterns of knowing explore the importance of applying empirics, ethics, aesthetics, personal, and emancipatory knowing in nursing practice. Nurses must engage in critical thinking and develop clinical judgement to evaluate a patient's condition and intervene effectively while also meeting professional, ethical, legal, and organizational responsibilities of nursing practice. The nursing process provides a systematic way for the nurse to assess, collect, and interpret data; plan and implement care; and evaluate the effectiveness of nursing interventions. A holistic health assessment evaluates the physical, psychological, developmental, cultural, and spiritual aspects of a patient's life, as well as the impact of social determinants of health on the individual's ability to attain, maintain, and regain health and wellness.



Knowledge Check

Quiz Text Description

1. MultiChoice Activity

The fundamental concepts of the nursing metaparadigm include

- a. nursing, health, illness and person
- b. nursing, person, hospital and illness
- c. person, nursing, health and environment
- d. person, health, illness and hospital

2. MultiChoice Activity

Which pattern of knowing is demonstrated when the student nurse researches the patient's medical diagnosis?

- a. aesthetic
- b. empirical
- c. ethical
- d. emancipatory

3. MultiChoice Activity

When the nurse challenges the status quo in the unit in relation to “not giving opioids to patients addicted to narcotics because they are junkies just looking for a fix”, the nurse applies

- a. aesthetic knowing
- b. ethical knowing
- c. empirical knowing
- d. emancipatory knowing

4. MultiChoice Activity

Which step of the nursing process is demonstrated while the nurse takes the patient's temperature following their plan to check the vital signs?

- a. implementation
- b. assessment
- c. diagnosis
- d. evaluation

5. MultiChoice Activity

The nurse administers pain medication to the patient because they complain about a headache.

According to the nursing process, what is the next step for the nurse to follow?

- a. evaluation
- b. diagnosis
- c. implementation
- d. assessment

6. MultiChoice Activity

The nurse provides wound care to the patient. They see that the area is red, hot to the touch, and there is more discharge from the wound than the last time the dressing was changed. The patient complains about increased discomfort from the wound. Based on the findings, the nurse concludes that the patient has developed an infection. Which phase of Tanner's clinical judgment is demonstrated by the nurse's diagnosis/main concern/priority of care?

- a. interpreting
- b. reflecting
- c. responding
- d. noticing

7. MultiChoice Activity

The patient complains of their inability to have a bowel movement and feeling nauseated. Following the nurse's assessment of the patient, the nurse decides to administer medication for constipation following the list of PRN (as needed) medications ordered by the physician. Which phase of Tanner's clinical judgment is demonstrated by the nurse's diagnosis/main concern/priority of care?

- a. reflecting
- b. interpreting
- c. noticing
- d. responding

8. MultiChoice Activity

According to Gillespie and Petersen's Situated Clinical-Decision Making Framework, the nurse must acquire knowledge about the patient's pathophysiology, including the pattern of the disease and expected trajectory. Knowing this information demonstrates which type of foundational knowledge?

- a. knowing the profession
- b. knowing the patient/client
- c. knowing the person
- d. knowing the case

9. MultiChoice Activity

When conducting a general survey following the ASEPTIC framework, the nurse assesses the patient's insight by

- a. asking if the patient realizes they are ill and need medical help
- b. noticing eye contact and facial expressions
- c. noticing if the speech is clear and logical

- d. asking the patient to spell the word “WORLD” backwards

10. MultiChoice Activity

When the patient tells the nurse, “I’ve always been a failure. Nothing ever goes right for me!”, which response demonstrates therapeutic communication?

- a. “You have so much to live for. Cheer up and keep going!”
- b. “You have been feeling like a failure for a while”
- c. “Your feelings are common when people are depressed.”
- d. “Why do you think you are a failure?”

Solution:

- 1. c. person, nursing, health and environment
- 2. b. empirical
- 3. d. emancipatory knowing
- 4. a. implementation
- 5. a. evaluation
- 6. a. interpreting
- 7. d. responding
- 8. d. knowing the case
- 9. a. asking if the patient realizes they are ill and need medical help
- 10. b. “You have been feeling like a failure for a while”



For Further Reflection

How will you make sure you engage in critical thinking, develop clinical judgement, and become used to thinking like a nurse?

- Video: “Think Like a Nurse” by BYU Nursing [3:17] is licensed under the Standard YouTube License .*Transcript and closed captions available on YouTube.*
- Critical Thinking in Nursing: Tips to Develop the Skill

What would you do and say as the nurse?



7-year-old with depression: Case Study Analysis

Review the scenario

The public health nurse visits one of the schools in their caseload and finds a teacher's request to meet a 7-year-old dealing with depression following the parents' divorce. The child has also been experiencing bullying at school, and the teachers are worried.

Key Points

- Introduce yourself to the client and let them know you are a (student) nurse. Speak and relate accordingly, given the child's age and school environment
- Establish a TNCR. It is very important to ensure that the child feels safe with you, and they can trust and speak freely to you
- Ask the child about school and home in general. Ask about hobbies and things they enjoy doing
- Inquire about significant others and support system(s)
- Ask the child how they are doing and how they are feeling. Find out if there is anything they are worried about. What are their wishes, dreams, fears, etc.?
- Let them know that their teacher wants to make sure they are ok. Confirm that the parents are getting divorced and assess the change in the family dynamics
- Find out how the child is coping with change and new routines. Ask if they are sleeping and eating, and if there are any changes in their elimination routines (pooping and peeing)
- Discuss school in general, including activities they enjoy doing and do not like to participate in
- Ask about problems at school in general and specifically with classmates. Confirm there is bullying taking place and validate the patient's feelings
- Let the child know that the teachers are worried about bullying. Research available resources in the school and the community in general
- Get as much information as possible about the bullying taking place from the child, teachers, and other classmates
- Find out from the teachers and the school principal about their process for dealing with bullying. Inquire about school policy and resources available to the staff and students
- Inquire if the parents have been notified about the bullying
- Assess the client's needs, research available resources, plan and implement potential care/use of

resources. Following the implementation of your plan, document and evaluate the effectiveness of your nursing interventions

- Plan to educate the teachers, parents, and students about bullying and discuss available resources in the school and community. Assess their needs regarding coping strategies and dealing with bullying, including anger management, grief counselling, and any other related needs that come up following your assessment and data collection

CHAPTER 4: HEALTH HISTORY, DATA COLLECTION, DOCUMENTATION, AND REPORTING

Chapter Overview



- 4.0 Learning Objectives
- 4.1 Chapter Introduction
- 4.2 Health History Interview: Pre-Orientation Phase
- 4.3 Health History Interview: Orientation Phase
- 4.4 Health History Interview: Working and Termination Phases
- 4.5 Health History Interview: Data Collection and Conclusion
- 4.6 Key Areas to Explore in a Subjective Health Assessment
- 4.7 Data Collection: Subjective vs. Objective Data
- 4.8 Nursing Interventions
- 4.9 Documentation
- 4.10 Reporting
- 4.11 Chapter Summary

4.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Demonstrate how to integrate the phases of the TNCR, ADPIE, and the health history interview when conducting a holistic health assessment.
2. Conduct a health history interview.
3. Differentiate between subjective and objective data collection.
4. Demonstrate critical thinking and clinical judgement when practicing health interviewing, collecting data, and planning appropriate nursing interventions.
5. Apply professional, ethical, and legal standards of nursing practice when conducting interviews.
6. Examine ways to practice and promote the safety of the patients, nurses, and health care team in a competent, ethical, and compassionate manner.

4.1 Chapter Introduction

Nurses must assess their patients in a holistic manner that includes physiological, psychological, developmental, psychosocial, and spiritual health needs. They must also consider the impact that families and communities can have on individuals. Nurses must conduct a health history to collect detailed information about the patient's human response to illness and life processes. The health history is part of the assessment phase of the nursing process and a critical component of a holistic health assessment. After establishing a TNCR, the nurse uses therapeutic communication skills, including focused and open-ended questions, to obtain information about symptoms, perception about the illnesses and health challenges, overall functioning, and coping. While obtaining a health history, the nurse simultaneously performs a general survey ("Chapter 2: Health History," 2021).

The Complete Subjective Health Assessment

For a more detailed overview of the components of the Health History Interview, see *Appendix B.2 The Complete Subjective Health Assessment* of this text more information.



What would you do and say as the nurse?

A 65-year-old who has been dealing with heart and respiratory problems for most of their life has also been newly diagnosed with Parkinson's disease. Given the many challenges that the patient is facing, they have been referred to the community palliative team by their family's physician. The community palliative nurse must do the first visit and intake assessment.

4.2 Health History Interview: Pre-Orientation Phase

Regardless of the setting, nurses must establish a professional working relationship to provide care to patients. The health history interview helps the nurse obtain the necessary subjective and objective data to identify appropriate nursing diagnoses or priorities of nursing care and decide how to best help the patient following professional, ethical, legal, and organizational responsibilities of nursing practice. Establishing a TNCR helps the nurse understand what is important to the client. Conducting a holistic health assessment assists the nurse in providing care from a humanistic patient-centred perspective that meets the patient's needs.

Components of a Nursing Health History

For an overview of the components of a nursing health history, see

Appendix B.2 Components of a Nursing Health History of this text for more information.

Overview of the Client Interview Process

The client interview is an important component of nursing practice and involves several sources, as reflected in Figure 4.2.1. It involves communicating with the client, who is considered the *primary source*, to collect *subjective data* (i.e., information that the client shares with you or the client's family/friends). The client interview may also involve collecting data from *secondary sources* such as family, friends, and other healthcare providers. It is part of your assessment in which you learn about the client and combine the collected data with objective data (information that you collect when performing a physical exam)(CNO, 2025d).



Figure 4.2.1: Interview sources. Image: Jennifer Lapum et al., 2020.

As a nurse, you must ensure that the client interview is informed by the *CNO Professional Boundaries and Nurse-Client Relationships*, because therapeutic communication and relationships are the foundation of an effective client interview. To meet this standard, you must think carefully about how to communicate while conducting the client interview.

The importance of good communication cannot be overstated. It is a foundational pillar of a good interview. The interview often serves as the impetus for therapeutic action. For example, without a client disclosing chest pain, it would be difficult for you to interpret what is wrong or ailing the client. The care provided by nurses is contingent on the accuracy of the data they collect, so nurses must develop their relational skills to accurately and holistically gather useful data from clients. If data are lacking, nurses are limited in providing effective care. For example, clients may not share certain problems if they are unsure whether you care or are interested. Also, clients may be afraid to reveal relevant health information because they fear judgment or ridicule, which could impede your ability to address their health issues.

The nature of the interview is influenced by the *interview purpose*. For example, an interview may be short and focused, or it may be more detailed and comprehensive, depending on the client's health needs/reason for seeking care. The interview purpose is often influenced by where you work, for example, an acute or primary care setting. No matter what the purpose, there are common principles and strategies to incorporate when conducting the interview, as detailed in the upcoming sections.

Steps for Conducting a Health History Interview

For an overview of the 6 Steps for Conducting a Health History Interview, see *Appendix B.3 Steps for Conducting a Health History Interview* of this text for more information.

Points of Consideration

Care Partners: The term care partners refers to family and friends who are involved in helping to care for the client. They may be referred to as informal caregivers or family caregivers, but care partners is a more inclusive term that acknowledges the energy, work, and importance of their role.



Activities: Check Your Understanding

Activity 1

Text Description

Which findings reflect subjective data? **Select all that apply.**

- a. The client's daughter says the client fell at home.
- b. The nurse observes the client crying.
- c. The client says, "I have pain."
- d. The nurse observes that the client's ankle is red and swollen.
- e. The client tells the nurse, "I have an itchy arm."

Solution:

Correct answer(s): a. The client's daughter says the client fell at home.; c. The client says, "I have pain."; e. The client tells the nurse, "I have an itchy arm."

Activity 2

Text Description

Drag and drop data from a primary or secondary source into the correct category.

1. The client tells the nurse they are feeling unwell. ____
2. The client informs the nurse that they fell off a ladder. ____
3. The client's father tells the nurse that their child is having trouble pronouncing words. ____
4. The client's partner explains that the client has been having difficulty breathing for a week. ____
5. The client's neighbour indicates that they found the client lying on the driveway outside their house. ____
6. The client states, "I have been having pain in my left hip for over a year, but it has recently become worse." ____

Possible answers:

- Data from a secondary source.
- Data from a primary source.
- Data from a primary source.
- Data from a secondary source.
- Data from a primary source.
- Data from a secondary source.

Solution:

1. The client tells the nurse they are feeling unwell. **Data from a primary source.**

2. The client informs the nurse that they fell off a ladder. **Data from a primary source.**
3. The client's father tells the nurse that their child is having trouble pronouncing words. **Data from a secondary source.**
4. The client's partner explains that the client has been having difficulty breathing for a week. **Data from a secondary source.**
5. The client's neighbour indicates that they found the client lying on the driveway outside their house. **Data from a secondary source.**
6. The client states, "I have been having pain in my left hip for over a year, but it has recently become worse." **Data from a primary source.**

Based on the phases of the TNCR, the phases of the health interview consist of the pre-orientation, orientation, working, and termination phases. Even when the patient is unresponsive and/or requires emergency care, a nurse must always introduce themselves and provide clear information about what is happening and the care that will be provided to the patient, following professional, ethical, and legal responsibilities of nursing practice.

Pre-Orientation Phase

Preparing for the Interview

You should review the *client's existing health record/chart* (if applicable) so that you have a general overview of the client's main health needs/reason for seeking care and health history. If the client is already admitted, this review will not only give you an overview of the health history, but also their last 24 hours. This is an important first step for several reasons:

- It conveys your interest and competence as a provider.
- It allows you to follow up on missing data.
- It saves the client from repetition.
- It allows you to identify any changes in the client's health status.

You should also consider how to leverage the interview location's environment and your position within it. The client interview is often conducted in locations such as clinic rooms, hospital rooms, emergency rooms, and community spaces, such as the client's home. You should attend to the following principles:

- Create a *quiet location* so that both you and the client can hear and communicate. Some possible strategies to reduce sound may include closing the room door, closing the curtains, and turning off radios and televisions.
- Establish a *welcoming environment*, which may include offering the client a place to sit and avoiding physical barriers between you and the client, such as a desk.
- Attend to the *client's physical comfort*, which may include offering them a drink of water and inviting them to take their coat off or have a place for them to put their bag/purse. Additionally, if they are in bed, you should ensure that they are comfortable and ask if they want to sit up, if they are permitted.
- Create an *inclusive space* in which care partners are invited to be part of the interview based on the client's wishes.
- Ensure a *private space* so that the client feels comfortable sharing personal information and that this information is kept confidential. Sometimes it will not be possible to ensure a completely private space, such as when a curtain is the only barrier. In this case, try to avoid using the client's name and other client

information loudly so that others can't overhear.

- Maintain *professional boundaries* (CNO, 2025d): This facilitates a trusting and therapeutic relationship between nurse and client rather than a personal and unprofessional relationship. You must understand your professional role and ensure that your relationship with the client does not become personal (e.g., meeting the client outside of work hours, disclosing personal information, or accepting/exchanging gifts). Crossing professional boundaries is considered professional misconduct (CNO, 2025d). Because of the power imbalance, crossing these boundaries can “create role confusion, increase client vulnerability and lead to negative client outcomes” (CNO, 2025d, pg. 8).

Before the client interview, you must be aware of the legislation and nursing standards regarding *privacy and confidentiality*. The Personal Health Information Protection Act (2004) states that clients have the right to have their personal health information kept private, and healthcare professionals are legally required to keep this information confidential. You must emphasize that client data is kept confidential and only shared with relevant members of the healthcare team directly involved in the client's care. When information is not kept confidential, it can undermine trust and the nurse-client relationship. As a result, clients are less likely to share sensitive information because they may question the healthcare provider's integrity.

You may want to re-emphasize confidentiality when addressing sensitive interview topics such as trauma and violence, sexual health, and substance use. The client owns their personal health information; as a custodian of this information, you must request permission before disclosure (CNO, 2025b). However, there are certain situations where consent for disclosure is not required (e.g., “to eliminate or reduce a significant risk of harm to a person” [CNO, 2025e]).

Points of Consideration

Abuse and Neglect

In certain conditions, a nurse must disclose personal health information. You are legally required to report suspected child abuse or neglect, and elder abuse when the person lives in a retirement or long-term care home in Ontario. You must report to a children's aid society “if you have reasonable grounds to suspect that a child is or may be in need of protection” (Ontario Ministry of Children, Community, and Social Services, n.d.). For a client in a retirement home, you must report to the Registrar of the Retirement Homes Regulatory Authority, and for a client in a long-term care home, report to the Director at the Ministry of Health and Long-Term Care (Community Legal Education Ontario, 2019). You must also report to the College of Nurses of Ontario (2020) if a client discloses or you observe a “nurse who poses a serious risk of harm to patients” (sexual abuse, incompetent care, physical or mental incapacity to provide safe care, or professional misconduct).



Activity: Check Your Understanding

Quiz Text Description

1. MultiChoice Activity

In preparing for the client interview, what considerations are important for the nurse to reflect upon?

Select all that apply.

- a. Ensure the client is comfortable.
- b. Ensure a private space.
- c. Create an inclusive space where care partners are invited.
- d. Reinforce that information is confidential.
- e. Review the client's chart after the interview.
- f. Establish a welcoming environment.

2. MultiChoice Activity

While assessing an 8-year-old client, the nurse suspects abuse or neglect. Who is the nurse legally obligated to report this to?

- a. The Children's Aid Society.
- b. The unit manager or Director of Nursing.
- c. The physician overseeing the care.
- d. The police.

Solution:

1. a. Ensure the client is comfortable.; b. Ensure a private space.; c. Create an inclusive space where care partners are invited.; d. Reinforce that information is confidential.; f. Establish a welcoming environment.;
2. a. The Children's Aid Society.

Self-Reflection Prior to the Interview

Like everyone, nurses are susceptible to stress, sadness, anger, and an array of other emotions. Despite good intentions, your communication will be strongly influenced by your mood, thoughts, and emotions. Self-reflection is an important tool for recognizing your emotional state and minimizing unintentional miscommunication with clients, i.e., non-therapeutic communication. See *Table 4.2.1* for strategies on how you can self-reflect before commencing the client interview.

Table 2.1: Self-reflecting on emotions and thoughts.

Reflective Practice	Consideration
How are you feeling?	Nurses are not exempt from life circumstances that can cause uncomfortable emotions like sadness, anger, frustration, as well as other emotions such as happiness and gratefulness. While it may be impossible to put aside your emotions, having a sense of your emotions and their cause is a very powerful tool to avoid inadvertent miscommunication.
What is occupying your thoughts?	It can be helpful to step outside of the narrative in your mind. It is not abnormal for a thought to pervade your thinking, but suspending such thoughts and being in the moment with the client can assist with better communication. Consider if something is weighing on you. Are you ruminating about an event, a person, an idea?
In what ways are you physically expressing your emotions and thoughts?	Your emotions and thoughts are sometimes physically expressed through facial expressions, hand gestures, and body language. Can someone tell that you are happy or sad by looking at you? Being aware of the physical expression of your emotions and thoughts can assist you in your communication with others and enable you to convey emotions like empathy, compassion, and concern.
How is your health and well-being?	Often, physiological and psychological/emotional events like hunger, fatigue, body aches, and sadness can shape your mood. Reflect on how you are feeling in relation to your body and mind, and pay attention to your body's cues.
What is the environment surrounding you?	Even when you think you are accustomed to the work environment, subtle triggers can affect your ability to effectively communicate. A beeping machine, foul smell, or bright lights may affect your ability to focus, show concern, and actively listen. Reflect on yourself in relation to the environment and consider what factors you can and cannot control.

As you self-reflect, consider that the *healthcare environment often intensifies emotions* for clients and their families. It can be a place where people experience pain, discomfort, and stress. Clients may hear bad news and confront truths about themselves, or experience intense joy and relief. Because such extremes can exist in the healthcare space, the client is often more attuned to you (the provider) than you may be aware. The client may be telegraphing your body language or intuiting your choice of words. For this reason, *providers need to be self-aware* and temporarily suspend their own needs in order to authentically connect with the client.

Points of Consideration

Mindfulness

Mindfulness can be a useful strategy for connecting with clients and authentically being fully in the moment as they respond. It's easy to get caught up in the fast-paced clinical environment and be distracted by preceding events. Clients pick up on distraction, and this can undermine trust. Mindful meditation has been proven to reduce stress among healthcare professionals, including nurses. Once learned, it can be used at any time and can improve your therapeutic communication with the client.

The *Client Interview* and *Self-Reflection* sections have been adapted from “The Client Interview,” and “Self-Reflection Prior to the Interview,” in *Introduction to Communication in Nursing* Copyright © 2020, edited by Jennifer Lapum; Oona St-Amant; Michelle Hughes; and Joy Garmaise-Yee, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted.

4.3 Health History Interview: Orientation Phase

■ There is a standard way to begin an interview so the client knows who you are and why you are there.

Introducing Yourself and Addressing the Client

As per the CNO (2026) Code of Conduct, begin by introducing yourself by *name* and *designation* and your *role* within the healthcare team to the client (consistent with the CNO public register), and determine how the *client wants to be addressed*. Also, best practice has shifted to include your own pronouns (if you use a pronoun) and ask what pronouns the client uses (if the client uses a pronoun) in order to create an inclusive environment. Although it is important to note that not all clients will use pronouns, in this case, you use their name. For example, an introduction may be: “Hello, I am Mac Li Ken Ji. I am a registered nurse and I will be supporting your recovery today. Please call me Mac. My pronouns are he/him. What name would you like me to use and what pronouns do you use if any?” It is important *not to use the term “preference”* when referring to pronouns and gender, as these are not preferences. Although you may first introduce yourself with your full name as per your CNO registration, you may also provide the name that you want the client to call you.

Because *registered nurse* and *nurse* are *protected titles*, you can only refer to yourself as a nurse when you are a member of the College (i.e., the College of Nurses of Ontario). If you are a nursing student, you should identify your designation based on your institutional requirements. For example, you may consider identifying the year of the nursing program you are in (e.g., nursing student year one, nursing student year two, nursing student year three, nursing student year four). For example, in year one of the program, you may say, “Hello, I am Misa Rodriguez. I am a nursing student in year one. My pronouns are they. You can call me Misa. I am working with your registered nurse, David, today.” As a nursing student, you should introduce yourself with your legal name (the name you are registered with your university/college), but you may also have a chosen/preferred name by which you can be called.

Identifying the Purpose of the Encounter

As per CNO (2026), part of the introduction phase of the client interview is to *identify your role*, which involves the purpose of the encounter. You should also notify the client that any information collected will be kept confidential and, if applicable, identify who the client's information will be shared with. Nurses often let clients know that they will also be taking notes.



Introduction Examples

Here are some examples:

- **Example 1:** I want to interview you about your illness. It will take about 10 minutes and will begin with me asking you some questions about how you are feeling. Is that okay? [client: yes]. I also want to let you know that everything you share will be kept confidential between myself and the health-care team who are involved in your care, which currently includes the physicians and the physiotherapists. [client: okay]. Please do note that I will be taking notes as we talk, and I will be asking you questions that help me understand how your health concerns and how best to care for you today. If you have any questions, feel free to ask at any time.
- **Example 2:** I see that you came into the clinic because you have been coughing. Before the physician arrives, I want to ask you a few questions about your cough. It will take about 10 minutes. Is that okay? [client: yes]. I also want to let you know that everything you share will be kept confidential between me and the healthcare team who are involved in your care, which includes your physician and me at this point. [client: okay]. Please do note that I will be taking notes as we talk, and I will be asking you questions that help me understand how you are feeling, your health concerns, and how best to care for you today. If you have any questions about my questions, feel free to stop me and ask.

See Film Clip 4.3.1 and 4.3.2, which demonstrate an effective and ineffective introduction to the patient interview.



Watch: Effective and Ineffective Introduction

Film 4.3.1: Effective interview introduction. (Also, consider sharing your own gender pronouns with the client. This creates an open and inclusive space in which the client may share their pronouns, if any. You can also ask what pronouns they use, but keep in mind that not all clients use pronouns. In this case, it is best to just use their name.)

Transcript: Effective Interview Introduction

Nurse: Hello, Mr. Almond. My name is Malaya Bautista.

Nurse: I am a registered nurse. How should I refer to you?

Francisco: Oh, you can call me Francisco.

Nurse: Thank you, Francisco. And who is with you today?

Francisco: Well, this is my daughter, Ainsley.

Nurse: Hello, Ainsley.

Ainsley: Hi.

Film 4.3.2: Ineffective interview introduction.

Transcript: Ineffective Interview Introduction

Nurse: Hello, this must be your daughter. I'm glad you came in with your dad today. How has he been sleeping?

Daughter: Um. I'm not sure. You could ask him.

Points of Consideration

Name and Designation

As a nurse, you are required to introduce yourself by your first and last name and your designation consistent with the CNO public register (CNO, 2026). By using your full name, you relay accountability and take responsibility for your work. There are situations when nurses may not use their full name or use a pseudonym, which is permitted as long as the employer is aware and the CNO is able to identify you through your employer; for example, this is permitted when you have reasonable grounds for your safety.



Activity: Check Your Understanding

Text Description

As per the College of Nurses of Ontario (CNO), how must nurses introduce themselves to the client?

Select all that apply.

- a. Include the nurse's name.
- b. Include the number of years that the nurse has been practicing.
- c. Include the name of the nurse who will be covering for them when they are on break.
- d. Include the nurse's category.
- e. Include the length of the shift that they are working.

Solution:

Correct answer(s): a. Include the nurse's name.; d. Include the nurse's category.;

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4.4 Health History Interview: Working and Termination Phases

The nurse must explore what is happening after the patient discloses the reason(s) for seeking help. It is important to understand the patient's goals while obtaining information about their health history. Nurses must use critical thinking to formulate a nursing diagnosis or priority to assist them in the development of a plan of care. Clinical judgement helps the nurse decide how to intervene while adhering to professional, ethical, legal, and organizational responsibilities. Nurses must be resourceful as they figure out what help is needed, connect the patient with the appropriate health care team member, and advocate for the patient to help them meet their goals. A TNCR and the use of therapeutic communication skills allow the nurse to apply the nursing process as they collect subjective and objective data and figure out how to best help the patient.

Review: The Importance of Therapeutic Communication

While many people may feel that they already know how to communicate well, professional nursing communication involves more than being friendly, empathetic, or naturally good at conversation. It requires the intentional integration of nursing science and the art of nursing practice. Nurses must learn how to use evidence-informed communication strategies while also responding with compassion, presence, and sensitivity to each patient's unique needs.

Effective therapeutic communication is a professional skill that is developed over time. Just as nursing students spend years learning the knowledge, judgment, and clinical skills required to become registered nurses, they must also practise how to communicate in ways that help patients feel heard, understood, respected, and supported. Although some individuals may be naturally caring and empathetic, it is the integration of nursing knowledge, clinical judgment, and relational practice that enables nurses to apply therapeutic communication effectively.

Resources

Below you will find resources to help you review key therapeutic communication skills:

- Types of Interviewing Questions
- Communication Strategies
- Non-Verbal Communication Strategies

Students are encouraged to return to this content often, review it carefully, and practise applying it in different clinical situations. Therapeutic communication is not something that can be fully developed through a single reading or lesson. It requires ongoing reflection, feedback, and practice.



Watch: AIDET

AIDET is a simple framework that helps communicate professionally with patients.

Video: “AIDET for Patient Communication | Nursing Fundamentals Theory | Lecturio Nursing” by Lecturio Nursing [3:47] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Termination Phase

Regardless of the setting and amount of time of the interaction, a nurse must always let the patient know that the encounter has ended. It is important to provide a quick summary of the key issues identified and plan for the next steps. It is good practice to always ask the patient if they have any questions or need anything before you leave them. Make sure to always check that they have access to and can use the call bell or whatever system they have available to get help when the need arises. Before you leave a patient, check that they are safe, comfortable, and their environment is also safe to prevent any harm or injury.

Concluding the Interview

Concluding the interview has three main purposes:

- First, to ensure that *you have understood everything* necessary in order to best care for the client.
- Second, to ensure that the client has had the *opportunity to share* what is important to them and add any additional information.
- And finally, to ensure that the client knows what the *next steps* are with regard to their care. Be specific and don't assume the client knows what to expect. Offer them handouts if available so they can review information at home.

As part of the conclusion, you should provide a brief summary of the data you have collected. This summary should reflect what the client said and may include paraphrasing what they said. You might start the summary off by saying, “The interview is coming to a close, and I would like to share a summary of what we discussed.” The length of the summary will depend on the comprehensiveness of the interview and the complexity of the client's needs, but it is usually a few sentences summarizing the pertinent data. This can be followed up by a couple of questions, such as “Did I capture what you said accurately?” and “Is there anything else that you would like to share with me that is important to your care?”

Finally, you should discuss the next steps related to the client's care. For example, these may include a physical assessment or having another health professional come in to talk with them. Make sure you ask the client if they have any questions before concluding the interview. Finally, close the interview in a therapeutic way, which may involve using the name that they prefer to be called and thanking them for sharing their information.

From Theory to Practice

You are a community palliative care nurse getting ready to visit a new client. You will need to do the first assessment and admit the patient to your team's roster. The patient is a 65-year-old who has been dealing with heart and respiratory problems most of their life. They are newly diagnosed with Parkinson's disease and were referred to your community palliative team by their family's physician.

Consider how you would organize yourself to conduct the first visit and intake assessment.

Reflect and write down what you would do in each phase of the holistic health interview during your first visit to collect information, get to know your patient, and establish a TNCR following professional, ethical, and legal responsibilities of nursing practice.

The *Termination Phases* section is adapted from "Concluding the Interview," in *Introduction to Communication in Nursing* Copyright ©2020, edited by Jennifer Lapum, Oona St-Amant, Michelle Hughes, and Joy Garmaise-Yee, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted.

4.5 Health History Interview: Data Collection and Conclusion

Nurses must collect information from the patient to continually assess and monitor their health status over time, which allows them to make appropriate clinical decisions in a timely and effective manner. Doing so leads to personalized individual care plans that improve and promote safety, evaluate treatment efficacy, and track long-term recovery. The collected information falls under subjective and objective data.

Reasons for Conducting a Complete Subjective Health Assessment

The aims of the nursing process are to identify the main health and illness concerns, determine the underlying issues/etiology, collaborate with the client to address and resolve these concerns, and identify the health needs of the client. The complete subjective health assessment is an important component of this process as it allows *insight into the client's state of health and illness*. Depending on the context and the client's primary health needs, the complete subjective health assessment may take up most of your time with the client.

You should conduct a complete subjective health assessment when a *comprehensive overview* of the client's health and illness is needed. For example, you may conduct a comprehensive subjective health assessment when a client moves into a long-term care institution, and, depending on the institution, it may be repeated monthly. This assessment is also conducted when a client is admitted to a hospital, and a shortened version of it is often completed at the start of each shift. However, the frequency and comprehensiveness of the assessment depend on the client's needs, the situation, and the institution's policies.

More *focused assessments* are required when collecting specific subjective data based on the health issues and/or need to clarify or follow up on previous information provided. Situations that warrant a focused assessment as opposed to a complete subjective health assessment include:

- An emergency (i.e., a situation with imminent catastrophic risk if untreated). In this case, you focus on collecting data that is vital to stabilizing a life-threatening illness; it may be specific to airway, breathing, and circulation. An example is a client who arrives at the emergency department reporting "crushing chest pain." In this case, a focused assessment is conducted that attends to the reason for seeking care and may focus on questions about the cardiac and respiratory system.
- A continual in-hospital assessment. In this case, you assess a client several times throughout your shift. The assessment focuses on the client's current main health issues and following up on health issues that were previously addressed.
- Primary care assessment. In this case, you focus your assessment on an emergent issue that has arisen for a client (e.g., a rash, pain in their knee, a fever). However, some primary assessments require a complete subjective health assessment, particularly if this is a client you are meeting for the first time or they have a complex health issue.



Activity: Test Your Understanding

Text Description

Which client requires a complete subjective health assessment?

- a. A person who has been a client at your clinic for 10 years and has requested an appointment about nail discolouration on their feet.
- b. The client who rings the call bell as they are having pain at about halfway through your shift.
- c. A client who you are seeing for the first time and is being admitted to the hospital for surgery.
- d. An unconscious client who was brought into the emergency department following a car accident.

Solution:

Correct answer(s): c. A client who you are seeing for the first time and is being admitted to the hospital for surgery.

The Complete Subjective Health Assessment

The complete subjective health assessment is commonly referred to as a *health history*. It provides an overview of the client's current and past health and illness states. You conduct it by interviewing the client as illustrated in *Figure 4.5.1*, asking them questions, and listening to their narrative.



Figure 4.5.1: Nurse interviewing the client

This information is often shared verbally with you or in a way that the client can best communicate. It is also sometimes collected through a standardized form that the client completes. In some cases, it also includes information shared by a family member, friend, or another health professional when the client is unable to communicate.

Points of Consideration

Care Partners

Clients are sometimes accompanied by care partners. Care partners are family and friends who are

involved in helping to care for the client. You may hear care partners being referred to as “informal caregivers” or “family caregivers,” but “care partner” is a more inclusive term that acknowledges the energy, work, and importance of their role.

The complete subjective health assessment is part of the assessment, the first component of the nursing process (assessment, analysis/diagnosis, planning, implementation and evaluation) outlined in *Figure 4.5.2*.

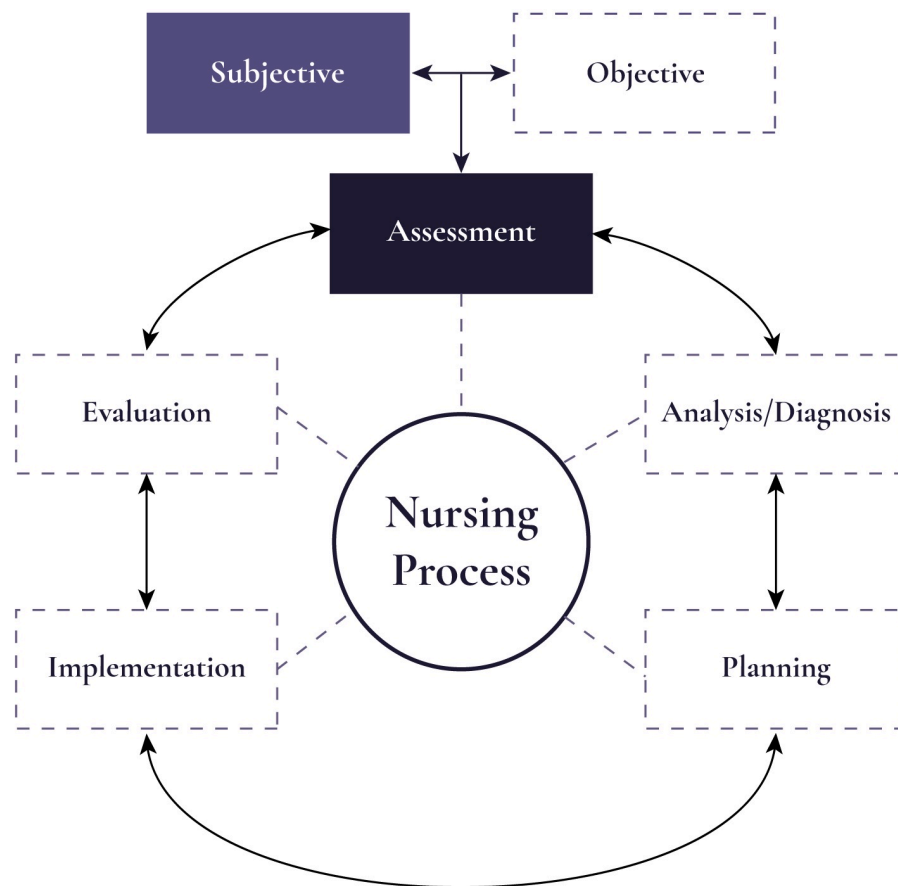


Figure 4.5.2: The nursing process

Image Description

The diagram presents the nursing process as a continuous cycle. At the top, subjective and objective information are connected and directed downward into assessment. Assessment is shown as a key step that connects to the rest of the process. Around the central label “Nursing Process” are four additional steps: analysis/diagnosis, planning, implementation, and evaluation. Arrows connect the steps to show that nurses move through the process in a cycle and may return to earlier steps as patient needs change.

As illustrated in Figure 4.5.2, the assessment phase of the nursing process involves collecting *subjective data* (information that the client shares) and *objective data* (information that you collect when performing a physi-

cal exam). See *Table 4.5.1* for an overview and examples of subjective and objective data. This book focuses on subjective data collection in the context of the complete subjective health assessment.

Table 4.5.1: Overview and Examples of Subjective and Objective Data

Data	Example
Subjective Information that the client shares with you spontaneously or in response to your questions.	• The client states, “I have had a rash on my ankle and leg for the last two weeks.” • The parent states, “My eight-month-old son is having trouble breathing.” • The client’s reason for seeking care is “diarrhea for 10 days.” • The client types, “I feel sick to my stomach.”
Objective Information that you observe when conducting a physical assessment, and lab and diagnostic results.	• You observe that a client has a bright red rash on the dorsal side of the foot, the lateral malleolus, and anterior and lateral side of the lower leg. • You observe the client sitting upright, leaning forward, breathing fast with eyes wide open. • You take the client’s blood pressure and report it as 112/84 mm Hg and pulse at 84 beats per minute. • Lab test results: K⁺ 4.0 mmol/L, fasting glucose 4.8 mmol/L. • Chest X-ray report: Lungs well-inflated and clear. No evidence of pneumonia or pulmonary edema.

As the word “subjective” suggests, this type of data refers to information that is spontaneously shared with you by the client or is in response to questions that you ask the client. Subjective data can include information about both symptoms and signs. In the context of subjective data, *symptoms* are something that the client feels, as illustrated in *Figure 4.5.3* (e.g., nausea, pain, fatigue). You won’t know about a symptom unless the client tells you. *Signs* are observable phenomena, such as a rash, bruising, or perspiration, as illustrated in *Figure 4.5.3*. Although you can observe signs, in the context of a subjective assessment, the client shares this subjective information with you. For example, a rash is both subjective and objective data, as it could be something that the client shares with you, but it is also something that you can observe. On the other hand, if the client says that the rash is itchy, that would be considered subjective data and, in this case, it would be a symptom because it is something the client feels and you can’t observe.



Figure 4.5.3: Symptom versus sign



Activity: Test Your Understanding

Quiz Text Description

Question 1: Fill-in-the-blank question: Information that the client shares with the nurse is considered ____ data.

Question 2: Drag-and-drop activity with two categories: Subjective and Objective. Learners sort five examples into the correct category: lab results concerning the client's hemoglobin levels have been placed in the client's chart; the client informs the health professional that they are having pain; the health professional observes that the client is sweating profusely; the client tells the health professional, "I have severe bruising on my legs"; and the friend of an unconscious client tells the health professional the client fell off the roof of a house.

Question 3 text: Drag-and-drop activity about signs and symptoms. Learners drag the labels "Sign" and "Symptom" to the image they best describe. One image shows a seated person with a visible red rash on their arm. The other image shows a seated person holding their arm with a thought bubble that says, "My arm is itchy."

Solution:

1. Information that the client shares with the nurse is considered **subjective** data.
2. **Objective:** The health professional observes that the client is sweating profusely. Lab results concerning the client's hemoglobin levels have been placed in the client's chart.
Subjective: The client informs the health professional that they are having pain. The client tells the health professional, "I have severe bruising on my legs." The friend of an unconscious client tells the health professional that the client fell off the roof of a house.
3. Seated person with a visible red rash on their arm: **Sign**
Seated person holding their arm with a thought bubble: **Symptom**

You begin the assessment with an introduction, followed by collecting information about demographic and biographic data and then the main health needs. Afterwards, there is no specific order in which these categories must be assessed. Often, it depends on the client's main health needs or reasons for seeking care. Sometimes it depends on the natural flow of conversation that occurs with the client. Usually, you assess sections that involve sensitive questions as well as cultural health towards the end, when you have had the opportunity to develop a level of trust with the client. Remember, when introducing yourself, state your full name, designation, and pronouns, and then ask the client what name and pronouns you should use to refer to them. It is important not to use the term "preference" when referring to pronouns and gender, as these are not preferences.

In addition to these categories, you may incorporate subjective questions specific to each of the body's systems; this phase is called a *Review of the Systems*. These questions give you insight into each body system (e.g., skin, eyes, cardiovascular, musculoskeletal). Depending on the client's response and the reporting of cues that prompt your concern, you may probe further with more specific questions. In other readings, you will learn about subjective questions related to each body system.

Clinical Tip

Always ask one question at a time.

Influencing Factors

Influencing factors constitute common situational issues that can arise during a subjective data assessment. Always consider *factors that may influence how you ask questions* and the validity and reliability of the subjective data collected. These situational factors can be difficult to both assess and address in certain cases (see Table 4.5.2).

Table 4.5.2: Influencing Factors and Strategies

Factors	Strategies
Clients may be hyperaware of the situation and wonder why you are asking certain questions.	• Begin by sharing with the client why you are asking these types of questions. • Encourage the client to ask you questions if they are uncertain about why certain information is being sought. • Normalize sensitive questions by stating: "I ask all clients about X so that I can better understand the context of their health and illness."
Clients may downplay or exaggerate what they tell you.	• Seek clarification. • Reframe the questions you ask. • Paraphrase what the client says and ask if you have captured their meaning correctly.
Clients may withhold information because they fear sharing information, feel judged by sharing certain information, and/or have a condition that is often stigmatized.	• Emphasize confidentiality. • Introduce sensitive questions later in the interview once you have established a therapeutic and trusting relationship.
Clients may not be fully conscious or oriented due to a physical injury, a mental health condition, a traumatic event, or substance use.	• It is important to be patient and give clients time to think and respond to your questions. • You may need to delay asking some questions until the client begins recovering. • If appropriate, ask other people who can share information about the client to corroborate it. Note: With a client who is under the influence of a substance, it is important to avoid prejudice, remain nonjudgmental, treat them with respect, speak slowly and clearly with simple language, provide a safe environment for them, and continue to monitor while observing changes in behaviour and level of consciousness.
Clients may function at a developmental age (as opposed to actual age). Developmental age is the age at which a client functions on a cognitive, physical, emotional, and social level. You need to consider this factor across the lifespan for all ages.	• Tailor your language and tone of voice to the client's developmental age. • Always use a respectful and professional tone. • Create space for others to be involved and/or invite a care partner to be present.

Points of Consideration

It is important to document who provides the subjective data. Usually, *subjective data* is provided by the client's *primary source*, but in some situations it may be collected from the client's chart, family members, friends, co-workers, care partners, or interpreters (*secondary sources*). In certain cases, the client may be unable to speak or share information, or may speak a different language from you, or be unconscious. Additionally, a care partner (such as a family member) may need to provide subjective data for a newborn or a client with developmental, cognitive, or mental health states that prohibit them from speaking.



Activity: Test Your Understanding

Quiz Text Description

1. Blanks Activity

The client's father is considered a ____ (Hint: It is either a primary or secondary source of data) source of data.

2. MultiChoice Activity

A client is admitted to the hospital after a violent physical assault that occurred while walking home alone. The client is responding slowly to your questions. What should the health professional do?

- Ask the client if they understand what you are saying.
- Restate the question in another format so that the question is clearer.
- Seek out a secondary source to provide information.
- Tell the client to take as much time as they need to answer the questions.

Solution:

- The client's father is considered a **secondary** source of data.
- d. Tell the client to take as much time as they need to answer the questions.

Concluding the Interview

Concluding the interview has three main purposes:

- First, to ensure that *you have understood everything* necessary in order to best care for the client.
- Second, to ensure that the client has had the *opportunity to share* what is important to them and add any

additional information.

- And finally, to ensure that the client knows what the *next steps* are with regard to their care. Be specific and don't assume the client knows what to expect. Offer them handouts if available so they can review information at home.

As part of the conclusion, you should provide a brief summary of the data you have collected. This summary should reflect what the client said and may include paraphrasing what they said. You might start the summary off by saying, "The interview is coming to a close and I would like to share a summary of what we discussed." The length of the summary will depend on the comprehensiveness of the interview and the complexity of the client's needs, but it is usually a few sentences summarizing the pertinent data. This can be followed up by a couple of questions, such as "Did I capture what you said accurately?" and "Is there anything else that you would like to share with me that is important to your care?"

Finally, you should discuss the next steps related to the client's care. For example, these may include a physical assessment or having another health professional come in to talk with them. Make sure you ask the client if they have any questions before concluding the interview. Finally, close the interview in a therapeutic way, which may involve using the name that they prefer to be called and thanking them for sharing their information.

"Reasons for Conducting a Subjective Health Assessment," "The Complete Subjective Health Assessment," "Influencing Factors" and "Concluding the Interview" sections have been adapted from The Complete Subjective Health Assessment Copyright © 2019 by Jennifer Lapum; Oona St-Amant; Michelle Hughes; Paul Petrie; Sherry Morrell; and Sita Mistry, which is licensed under a Creative Commons Attribution-ShareAlike 4.0 International License, except where otherwise noted.

4.6 Key Areas to Explore in a Subjective Health Assessment



Categories for a Subjective Health Assessment

Categories of the complete subjective health assessment (as illustrated in *Figure 4.6.1*) vary depending on the framework you follow.

Categories of the Subjective Health Assessment

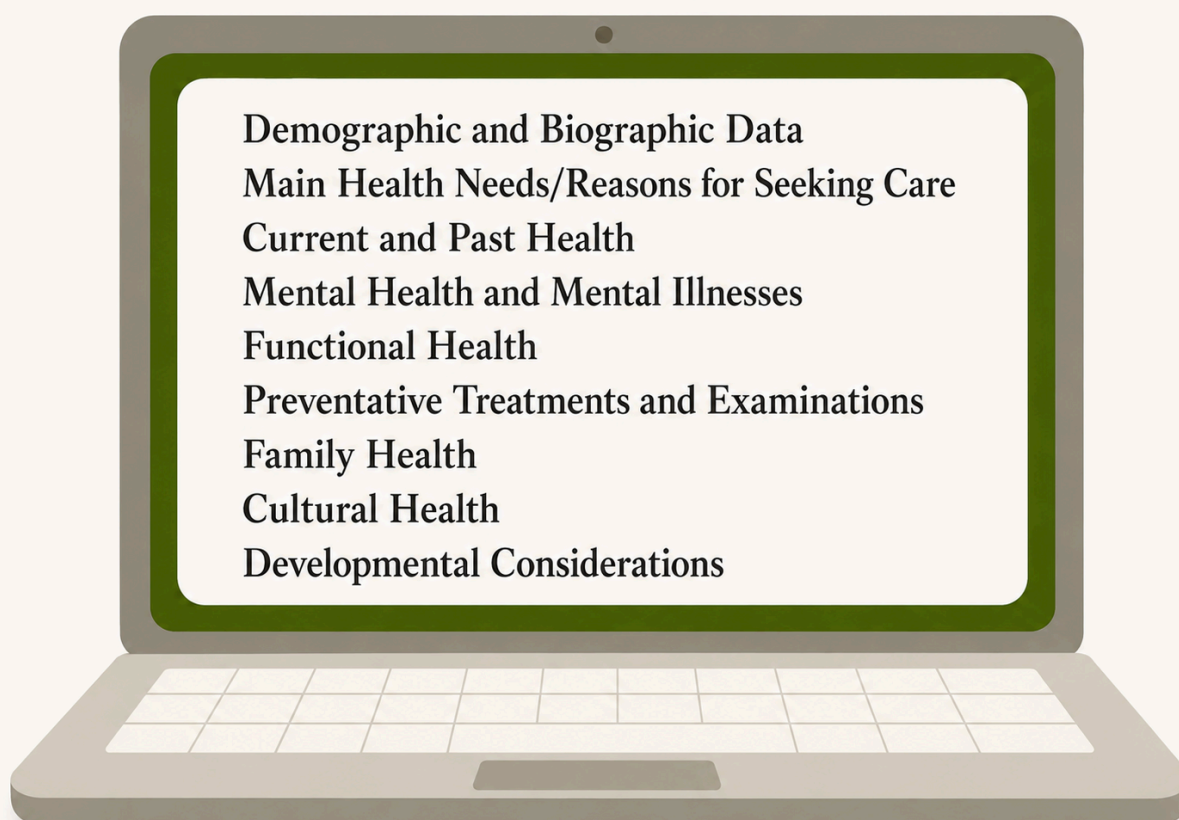


Figure 4.6.1: Categories of the Subjective Health Assessment

Category Details

For a complete description, review *Appendix A: Subjective Health Assessment Categories* for each of the following categories:

- Introductory information: Demographic and biographic data
- Main health needs (reasons for seeking care)
- Current and past health

- Mental health and mental illnesses
- Functional health
- Preventive treatments and examinations
- Family health
- Cultural health
- Developmental Considerations

4.6.1 OLDCARTSS

Any time a patient voices a concern, issue, health challenge or problem to the nurse, this must be carefully assessed to determine how to intervene. OLDCARTSS is a framework for assessing the situation. It consists of onset, location (including radiation), duration, characteristics, aggravating factors, relieving factors, timing, and severity. Sometimes, people use L for location, A for aggravating and alleviating factors, and R for radiation. Sometimes, people add an extra S at the end to include the patient's self-perception of the health challenge/issue/problem they are experiencing or the reason they are seeking help.

Learning Resources

- Mastering OLDCARTS: The First Step to Thinking Like a Clinician
- OLDCARTS mnemonic

From Theory to Practice

You are at the health clinic and have been assigned to a new patient who just came in.

What would you say and do in the role of the (student) nurse, making sure you follow professional, ethical, and legal responsibilities of nursing practice?

The video below demonstrates how you would put all the key areas of a complete subjective health assessment together:

Video: "Nursing OER: Health Assessment – Demographic and Biographic Data" by eCampusOntario and Leigh Meta [1:58] is licensed under a CC BY-SA 4.0. *Transcript and closed captions available on YouTube.*

This is an example of an OLDCARTSS assessment for Nursing students and was created at Fanshawe College. Student contributors in this video: Mick Millette and Jill Canterbury (*patient roles*).

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Modifications: Image 4.6.1 recreated and updated.

OpenAI. (2026). Categories of the Subjective Health Assessment [AI-generated image]. ChatGPT.

<https://chat.openai.com/>

Prompt

Recreate the original image, and also add “Developmental Considerations” to the list directly below “Cultural Health”? Use the same colour accent scheme #495C0B.”

4.7 Data Collection: Subjective vs. Objective Data

Objective data includes all the information that can be measured and objectively, without bias, collected by the nurse. It includes vital signs and the specific system assessment or head-to-toe assessment findings obtained by the nurse. All diagnostic findings and lab results, which may not be collected by the nurse, are considered objective data.

Subjective Versus Objective Data

Obtaining a patient's health history is a component of the Assessment phase of the nursing process. Information obtained while performing a health history is called subjective data. Subjective data is information obtained from the patient and/or family members and can provide important cues about functioning and unmet needs requiring assistance. Subjective data is considered a symptom because it is something the patient reports. When documenting subjective data in a progress note, it should be included in quotation marks and start with verbiage such as "The patient reports..." or "The patient's wife states..." An example of subjective data is when the patient reports, "I feel dizzy."

A patient is considered the primary source of subjective data. Secondary sources of data include information from the patient's chart, family members, or other health care team members. Patients are often accompanied by their care partners. Care partners are family and friends who are involved in helping to care for the patient. For example, parents are care partners for children; spouses are often care partners for each other, and adult children are often care partners for their aging parents. When obtaining a health history, care partners may contribute important information related to the health and needs of the patient. If data is gathered from someone other than the patient, the nurse should document where the information is obtained.

Objective data is information observed through your senses of hearing, sight, smell, and touch while assessing the patient. Objective data is obtained during the physical examination component of the assessment process. Examples of objective data are vital signs, physical examination findings, and laboratory results. An example of objective data is recording a blood pressure reading of 140/86. Subjective data and objective data are often recorded together during an assessment. For example, the symptom the patient reports, "I feel itchy all over," is documented in association with the sign of an observed raised red rash located on the upper back and chest.

Links to Learning

Review the following additional resources for more information about the importance of Subjective vs. Objective data distinctions:

- Understanding the Role of Subjective vs. Objective Nursing Data
- Subjective vs. Objective Data in Nursing: Key Differences
- Understanding Subjective vs. Objective Nursing Data

- Subjective vs Objective Data in Nursing: A Complete Guide to Objective Nursing Data and Patient Assessment



Watch: ADPIE Nursing Process

Video: "How to perform a NURSING ASSESSMENT | ADPIE Nursing Process | Lecturio Nursing" by Lecturio Nursing [11:04] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

When you get a report from the day nurse, you receive information about your patient. Determine whether each statement is subjective (primary or secondary source) or objective data.

Justify your rationale using the theory about subjective and objective data:

- *The patient complained to the nurse about feeling nauseated.*
- *The patient vomited 150 mL (cc) of green fluid.*
- *Blood pressure was 120/80 mmHg at 1500.*
- *The patient's mom reported that her child told her they had a headache.*
- *The patient told the staff they felt very hot.*
- *The physician documented that the patient had decreased balance when standing.*
- *The last recorded temperature at 1800 was 39.0 C*

The *Subjective Versus Objective Data* section was adapted from "2.1. Health History Introduction" in *Nursing Fundamentals 2e* Copyright © 2024 by WisTech Open, which is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted. *Modifications: omitted sections on strategies for communicating with impaired hearing, vision, and speech.*

4.8 Nursing Interventions

Nurses must engage in critical thinking when assessing patients and collecting subjective and objective data to determine what is happening, and thus prioritize, plan, and implement their nursing care. Clinical judgment is necessary to decide what to do for the patient following professional, ethical, legal, and organizational guidelines. Recall the application of ADPIE and NANDA (nursing diagnosis) or nursing priority/concern to help prioritize nursing care, as well as use an antiracist, trauma-informed and strength-based nursing approach to help you establish a TNCR. Frameworks such as ASEPTIC, OLDCARTSS, and AIDET are helpful for collecting accurate information during patient assessment. Knowledge of the nurse's scope of practice, the patient's pathology, and the treatment in place is necessary to help the nurse decide what to do for the patient and intervene in a timely and effective manner. Additionally, nurses must always consider the safety of everyone involved, including the patient, the nurse, health care staff, and other patients and people who may be involved with the patient.

4.8.1 Thinking Like a Nurse

Clinical Reasoning and Decision-Making for Pain and Mobility

Clinical reasoning is a way that nurses think and process their knowledge, including what we have read or learned in the past, and apply it to the current practice context of what we are seeing right now (National Council of State Boards of Nursing [NCSBN], n.d.). Nurses make decisions all the time, but making decisions requires a complex thinking process. There are many tools that are useful and found online that can support your thinking through to clinical judgments. This book uses the nursing process and clinical judgment language to help you understand the application of medication to your clinical practice.

After reviewing basic concepts related to pain and several disorders requiring analgesic or musculoskeletal medication, it is time to consider how to make decisions about these types of medications.

Assessment

Although there are numerous details to consider when administering medications, it is always important to first think about what you are giving and why.

First, let's think of why? Recognizing Cues

Prior to the administration of any medication, nurses should perform an assessment and gather cues to analyze and prioritize a hypothesis (Tanner, 2006).

For instance, if considering a pain medication, you will want to complete a full pain assessment, such as determining a pain scale and acceptable pain level for your client. See *Figure 4.8.1* for common nursing mnemonics for pain assessment.

Nursing Mnemonics for Pain Assessment

Old Carts

O - Onset
L - Location
D - Duration
C - Character
A - Alleviating & Aggravating factors
R - Radiation
T - Treatments
S - Severity

PQRST

P - Provoking factors
Q - Quality
R - Region & Radiation
S - Severity
T - Time

Socrates

S - Site
O - Onset
C - Character
R - Radiation
A - Associated symptoms
T - Time span/duration
E - Exacerbating & relieving factors
S - Severity

Figure 4.8.1. Mnemonics for Pain Assessment. Image: “Mnemonics for Pain Assessment” by Julie Teeter, CC BY-SA 4.0.

Image Description

The image is titled “Nursing Mnemonics for Pain Assessment.” It compares three common mnemonics for guiding pain assessment: OLD CARTS, PQRST, and SOCRATES.

OLD CARTS includes:

- **O** – Onset
- **L** – Location
- **D** – Duration
- **C** – Character
- **A** – Alleviating and aggravating factors
- **R** – Radiation
- **T** – Treatments
- **S** – Severity

PQRST includes:

- **P** – Provoking factors
- **Q** – Quality
- **R** – Region and radiation
- **S** – Severity
- **T** – Time

SOCRATES includes:

- **S** – Site
- **O** – Onset
- **C** – Character
- **R** – Radiation
- **A** – Associated symptoms
- **T** – Time span or duration
- **E** – Exacerbating and relieving factors
- **S** – Severity

If administering a medication related to mobility or the musculoskeletal system, you will first want to collect data such as strength and stability. Additional baseline information to collect prior to administration of any analgesic or musculoskeletal medication includes any history of allergy or a previous adverse response.

Lifespan Considerations

Most medications are calculated based on the client's size, weight, and renal function. Client age and size are especially vital in pediatric clients. A child's stage of development and the size of their internal organs will greatly impact how the body absorbs, digests, metabolizes and eliminates medications.

Visual pain scales have been developed as a tool of communication about pain with children and clients at the end of life. See Figure 4.8.2 for the FACES Pain Rating Scale. To use this scale, use the following evidence-based instructions.

1. Explain to the client that each face represents a person who has no pain (hurt), some, or a lot of pain.
2. Explain, "Face 0 doesn't hurt at all. Face 2 hurts just a little. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have the worst pain."
3. Ask the client to choose the face that best represents the pain they are feeling.



©1983 Wong-Baker FACES Foundation. www.WongBakerFACES.org
 Used with permission. Originally published in *Whaley & Wong's Nursing Care of Infants and Children*. ©Elsevier Inc.

Figure 4.8.2. The Wong-Baker FACES Pain Rating Scale.

Image Description

The image shows the Wong-Baker FACES® Pain Rating Scale. It includes six illustrated faces arranged from left to right, showing increasing levels of pain or distress. Each face is paired with a number and a pain description.

- **0** – No Hurt: a smiling face
- **2** – Hurts Little Bit: a mostly happy face
- **4** – Hurts Little More: a neutral face
- **6** – Hurts Even More: a sad face
- **8** – Hurts Whole Lot: a very sad face
- **10** – Hurts Worst: a crying face

The scale is used to help patients communicate the intensity of their pain by selecting the face and number that best match how they feel.

Determinants of Health and Cultural Safety

There are several considerations for nurses when working with clients who have conditions related to pain and mobility. It is important that you engage in client care that is culturally safe, remember that pain is what the client says it is, and do not further marginalize clients (Craig et al., 2020).

Interventions

Next, plan (refine your hypothesis), and take action.

Once you have gathered your assessment data and cues, you'll begin to generate solutions to the concern that your client has. Prior to administration, it is important to consider the best route of administration for this client at this particular time. For example, if the client is nauseated and vomiting, then an oral route may not be effective.

There are also legal and ethical considerations when administering some analgesics such as opioids. When administering opioid medications, it is important to remember that these medications are controlled substances with special regulations regarding storage, auditing counts, and disposal or wasting of medication.

A general rule of thumb when administering analgesics is to use the least invasive medication that is anticipated to treat the level of pain reported by the client. The World Health Organization (WHO) pain ladder was originally developed for the selection of analgesics for clients with cancer, but it illustrates the concept that pain control should be based on the level indicated by the client. See Figure 4.8.3 for an image of the WHO ladder. For example, if a client reports a pain level of “2,” then it is appropriate to start at the lowest rung of the ladder and administer a non-opioid. However, it may be clinically indicated to start at “Level 3” on the WHO ladder for clients who present with severe, difficult pain.

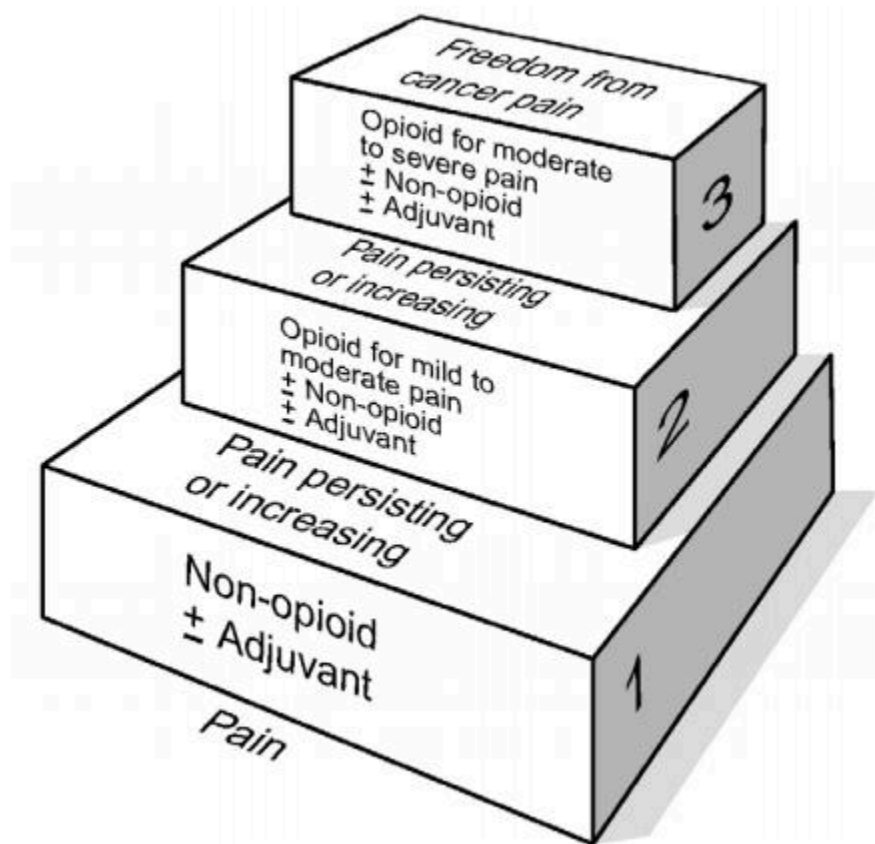


Figure 4.8.3. The WHO Pain Ladder. The diagram shows the step-wise approach to cancer pain management recommended by the World Health Organization (WHO). Image: World Health Organization. *Cancer pain relief*. 2nd ed. Geneva: WHO; 1996.

Image Description

The image shows a three-step ladder model for cancer pain management. The ladder begins at the bottom with pain and moves upward toward the goal of freedom from cancer pain.

- **Step 1:** Non-opioid medication, with or without an adjuvant.
- **Step 2:** If pain persists or increases, an opioid for mild to moderate pain may be used, with or without a non-opioid and with or without an adjuvant.
- **Step 3:** If pain continues to persist or increase, an opioid for moderate to severe pain may be used, with or without a non-opioid and with or without an adjuvant.

The image communicates that pain management can be adjusted step by step as pain persists or increases, with the overall goal of relieving cancer pain.

It is important to anticipate any common side effects and the expected outcome of the medication, as well as considerations regarding what to teach the client and their family regarding the medications. This information will be dependent upon the medication.

Evaluation

Finally, evaluate the outcomes of your action.

It is important to always evaluate the client's response to a medication. In most circumstances, the nurse should assess for a decrease in pain 30 minutes after intravenous (IV) administration and 60 minutes after oral medication. If the client's pain level is not acceptable, the nurse should investigate alternate treatment modalities. These modalities may include, but are not limited to, aromatherapy, repositioning the client, hot or cold treatments, and listening to music.

As the nurse is the client's advocate, the healthcare provider may have to be informed if the client's pain is not being controlled by analgesics. Nurses should also evaluate for any adverse effects. For instance, one adverse effect of opioid analgesics is respiratory depression. The nurse should evaluate the respiratory rate and pulse oximetry after administration of the medication. The nurse may need to consider administering other medications that treat the side effects of analgesic medication.

4.8.2 Acting Like a Nurse

After determining the nursing diagnosis, priority of care or key nursing concern(s), nurses must provide care following professional, ethical, legal, and institutional guidelines. Physicians are responsible for diagnosing pathology, so they need to order diagnostic procedures to help them determine and order a general medical treatment plan. Following the nurse's scope of practice and knowledge about the pathology of the patient and their unique needs, nurses can decide how to intervene and provide care in a safe, competent, ethical, caring, and compassionate manner that complements the general medical treatment plan of care.



Watch: On Scope of Practice

CNO Scope of Practice Overview

Video: "CNO Scope of Practice Overview FC" by The College of Nurses of Ontario (CNO) [1:12] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5 Clinical Skills that Every Nurse Should Master

Video: "5 Clinical Skills that Every Nurse should Master" by Pawan Sandhu [8:40] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

4.8.3 Safety

"First, do no harm" is the most fundamental principle of any health care service. No one should be harmed in health care; however, there is compelling evidence of a huge burden of avoidable patient harm globally across

the developed and developing health care systems. This has major human, moral, ethical, and financial implications. Patient safety is defined as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.” Within the broader health system context, it is “a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur” (WHO, 2026).

According to the World Health Organization (2026), common sources of patient harm include medication errors, surgical errors, health care-associated infections, sepsis, diagnostic errors, patient falls, venous thromboembolism, pressure ulcers, unsafe transfusion practices, patient misidentification, and unsafe injection practices.

Nurses play a critical role in ensuring patient safety while providing care to patients. They are a constant presence at the bedside and regularly interact with physicians, pharmacists, families, and all other members of the health care team. Therefore, nurses are crucial to ensure and promote timely coordination and communication of the patient’s condition to the team. From a patient safety perspective, a nurse’s role includes monitoring patients for clinical deterioration, detecting errors and near misses, understanding care processes and weaknesses inherent in some systems, identifying and communicating changes in patient condition, and performing countless other tasks to ensure patients receive high-quality care (Phillips et al., 2021; CNO, n.d.-d).

During and after a health history interview in a health care organization, ensure the 5 safety measures, which include:

- CALL LIGHT: Within reach. Check to make sure it works. The patient must be able to access and use it. If the call bell system is not appropriate for the patient, advocate and obtain a system that meets the patient’s needs
- BED: Low and locked (bed to the lowest position appropriate to the client with brakes on)
- SIDE RAILS: Secured and appropriate to the client’s situation
- TABLE: Within reach
- ROOM: Risk-free for falls (scan the room and clear any obstacles)(Health Canada [HC], 2017; Potter et al., 2019).



Watch: On Safety

Safety Checks

Video: “Safety Checks” by Maria Mobley, MSN, RN, NPD BC [13:37] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Bedside and Patient Safety Check

Video: “Bedside and Patient Safety Check” by Michelle Hunt [9:31] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

ISBAR Patient Safety

Video: “ISBAR Patient Safety” by Janet Beer [3:08] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

Watch video 1 and reflect on the effective, ineffective and non-therapeutic communication techniques used by the nurse:

- **Video 1:** Nurse-Patient Interview
- **Video 2:** Communication

Consider what you would say and do differently to improve the interaction in Video 1. How would you demonstrate therapeutic communication and establish a TNCR to help you collect accurate information from the patient during a holistic health interview? Write your thoughts, then watch Video 2 and compare it to your notes.

Adapted from “10.4 Clinical Reasoning and Decision-Making for Pain and Mobility” in Fundamentals of Nursing Pharmacology – 1st Canadian Edition Copyright © 2023 by Amanda Egert, Kimberly

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4.9 Documentation

Documentation is an essential component of safe, competent, and ethical nursing practice. It involves recording key information that provides evidence of a client's health status, needs or goals, communication with the health care team, the decision-making process and care provided, including outcomes and evaluations. This process supports both the delivery and continuity of care. Documentation can take many forms, which include but are not limited to paper-based records, electronic systems, electronically generated notes and audio or visual recordings. It may include clinical assessments, the rationale behind care decisions, and any changes in the client's condition. Whether documenting for individual clients, groups or communities, documentation supports collaborative practice. It ensures that all members of the health care team have access to clear, complete, and accurate information, which is essential for making informed decisions and delivering coordinated care. Documentation that meets this standard ensures accountability, enhances client safety, and supports legal and professional accountability. As technology continues to evolve, nurses are required to meet documentation requirements regardless of the format or platform used (CNO, 2025e).



Watch: Documentation Webinar

Video: "Documentation Webinar (English)" by The College of Nurses of Ontario (CNO) [12:55] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Learning Resources

- It doesn't matter what you say after the fact: "If it isn't written down, it didn't happen."
- Documentation in nursing practice

There are various formats for charting or documenting nursing care. Some of the most common include using:

- ADPIE (Assessment, Diagnosis, Planning, Implementation, and Evaluation) the nursing process.
- F-DAR (Focus, Data, Action, Response), which involves focusing on a specific patient concern, the nursing intervention, and the patient's reaction.
- SOAP/SOAPIE (Subjective data, Objective data, Assessment, Plan, Intervention, and Evaluation), which is a problem-oriented charting.
- Charting by Exception (CBE), which is an approach where only the findings that fall outside of the expected norms are documented, following the institution's guidelines.



Watch: On Documenting

Focus (FDAR) Charting

Video: "Focus Charting" by Carepatron [2:38] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

How to Make SOAP Notes Easy

Video: "How to Make SOAP Notes Easy (NCLEX RN Review)" by Mometrix Nursing [5:59] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

Your patient is scheduled to have surgery in the morning. When you meet them at the start of your night shift and start doing your assessment, the patient states, "I'm worried about controlling the pain after my surgery". Your VS findings are HR 98, BP 125/82, R 24, O2 sat 98%, T 37.0C, and the patient denies any pain. You notice the patient is restless and unable to sleep, pacing back and forth in the room. When you ask the patient if they are anxious, they tell you that they cannot stop thinking about pain control after surgery.

Write a SOAP note based on the patient situation above.

Watch the Nursing SOAP Note Example video and use it to help you evaluate your understanding of how to write a SOAP note.

4.10 Reporting

In accordance with documentation standards, nurses must communicate their assessment findings and update the team on the patient's progress and challenges to ensure the consistency and effectiveness of care. An accurate report can prevent harm to the patient, an inaccurate diagnosis, and a lack of communication and transparency about the general treatment plan. Reporting can also assist the nurse in advocating for the patient's needs and in ensuring that the team supports one another's challenges, including the patient's goals and needs.

There are many frameworks useful for organizing patient information and giving patient reports. ISBAR (Introduction, Situation, Background, Assessment, and Recommendation) or SBAR is commonly used in various health care settings. It can be used when talking to one another in person, using the phone, or in writing.



Watch: On Reporting

How to Give an SBAR Report

Video: “

How to give an SBAR Report | What is it and how SBAR used | Lecturio Nursing | Fundamentals Theory” by Lecturio Nursing [4:09] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

How to Give a Good SBAR

Video: “HOW TO GIVE A GOOD SBAR” by Ashley Lorena Adkins, MSN, RN, CCRN [3:57] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

How to Give an SBAR Handover

Video: “How to give a SBAR Handover | Clinical Skills Series” by Nurse Zara [7:37] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

You need to give a night report (a handover report at the bedside) to the day nurse. The specific case and patient data are as follows:

Mrs. Johnson, 65 y/o female, was admitted for pneumonia 3 days ago with a history of COPD. She has increased shortness of breath (SOB), 39.0 C0 temperature, and 88% oxygen saturation on room air.

Mrs. Johnson has been getting antibiotics and bronchodilators. She is in distress due to the increased work of breathing. She has decreased air entry bilaterally with scattered crackle lung sounds. Mrs. Johnson is lethargic and has increased oxygen requirements. You are thinking that she needs to be transferred to the Intensive Care Unit (ICU) so she can get close monitoring and respiratory support.

1. *Organize and write down the information to help you give an ISBAR*
2. *Practice giving an ISBAR on Mrs. Johnson*
3. *Watch a video of John giving a report to Sarah using ISBAR.*

4.11 Chapter Summary



Key Takeaways

When students are asked why they want to become a nurse, most answer that they want to help people and make a difference. Nurses must understand the science and art of nursing practice to help people. Applying the nursing process to assess and identify patients' challenges helps the nurse critically think about how they can help people attain, maintain, and regain health and quality of life, including a good death. However, nurses must understand what is important to patients, which helps them decide how to intervene in a safe, competent, ethical, caring, and compassionate manner that follows the professional, ethical, legal, and organizational responsibilities of nursing practice. To understand what is important to patients, nurses must establish a TNCR to conduct a health interview and ultimately a holistic health assessment that captures the person's awareness of their life experience as is, as perceived, and as lived.



Knowledge Check

Quiz Text Description

1. MultiChoice Activity

Which phase of the health interview relates to the nurse's focus on the patient's concerns as they help them problem-solve and meet identified needs?

- a. Termination
- b. Working
- c. Pre-orientation
- d. Orientation

2. MultiChoice Activity

Which of the following statements illustrates the next step of the health interview following a patient's complaint about a headache?

- a. The nurse checks the physician's orders
- b. The nurse calls pharmacy to get meds
- c. The nurse administers pain medication
- d. The nurse applies OLDCARTSS to assess pain

3. MultiChoice Activity

Which of the following is an example of subjective data collected by the nurse?

- a. blood work, vital signs, and MRI reports
- b. the patient's mother reports her child is nauseous
- c. the patient falls when asked to get up and walk
- d. the patient voids 500 mL of clear, yellow urine

4. MultiChoice Activity

Which of the following is an example of objective data?

- a. during team rounds, the physiotherapist states the patient refuses to exercise
- b. following report, the night nurse tells you that the patient seemed comfortable
- c. the patient tells you they are worried about what the doctor will order for meds
- d. the doctor's note states the latest result indicate the patient has a gliosarcoma

5. MultiChoice Activity

What information must be collected by the nurse when assessing medications?

- a. prescribed by the doctor, over the counter, recreational, and alternative
- b. prescribed by the doctor and alternative, including alcohol and allergies
- c. prescribed by a regulated provider, alternate therapy, and over the counter
- d. prescribed, over the counter, drug abuse, and any adjuvant therapies

6. MultiChoice Activity

What must nurses do regarding the use of bed rails?

- a. never put all 4 bed rails up for any of the patients
- b. always put at least 2 bed rails up for all the patients
- c. assess the patient and follow the agency protocol
- d. always put all 4 bed rails up for all the patients

7. MultiChoice Activity

What are the first priorities of the nurse, and student nurse, following professional, ethical, and legal responsibilities, when meeting a patient during the orientation phase of the health interview?

- a. let the patient know they will provide care and check the patient's name and day of birth
- b. tell the patient their name, check the patient's name, and ask the reason for seeking help
- c. introduce themselves, credentials, state what they will do, and get consent to provide care
- d. state their name then ask the patient for their name, day of birth, and preferred pronouns

8. MultiChoice Activity

What are the professional, ethical, and legal responsibilities of the nurse during the termination phase, just before leaving the patient's hospital room?

- a. put the bed all the way to the floor and always leave 2 side-rails up
- b. rearrange the room to suit the nurse's work needs and the patient's care
- c. check that the patient's ID is on and make sure the information is correct
- d. show the patient how to use the call bell and check they are able to use it

9. MultiChoice Activity

When correcting an error in documentation, a nurse should

- a. correct the error by drawing one line and initialling
- b. permanently erase the error using white out
- c. also correct any other errors made by other nurses
- d. correct the error by drawing many lines on the word

10. MultiChoice Activity

A patient is being transferred to the ICU. The nurse uses SBAR to give a report about the patient's condition. Which of the following pieces of information is included in the R portion of the SBAR?

- a. The patient's dressing should be changed as soon as possible
- b. The current BP is 120/78, HR 72, R 20, O2 sat 92% at 2 L via nasal prongs
- c. The physician prescribed amoxicillin for the patient's current infection
- d. The patient's condition is not stable, so they need to be in ICU

Solution:

1. b. Working
2. d. The nurse applies OLDCARTSS to assess pain
3. b. the patient's mother reports her child is nauseous
4. d. the doctor's note states the latest result indicate the patient has a gliosarcoma
5. a. prescribed by the doctor, over the counter, recreational, and alternative
6. c. assess the patient and follow the agency protocol
7. c. introduce themselves, credentials, state what they will do, and get consent to provide care
8. d. show the patient how to use the call bell and check they are able to use it
9. a. correct the error by drawing one line and initialling
10. a. The patient's dressing should be changed as soon as possible

**For Further Reflection**

When you become an RN, how will you ensure you can always provide safe, competent, ethical, caring, and compassionate nursing care to your patients as you attempt to help them and make a difference in their lives?

- Video: "Things Nurses Should Know" by RegisteredNurseRN [6:01] is licensed under the Standard YouTube License.

What would you do and say as the nurse?



65-year-old with Heart and Respiratory Problems: Case Study Analysis

Review the scenario

Key Points

- **Pre-Orientation Phase:** obtain as much information as possible regarding the patient. Organize the necessary equipment needed to conduct a holistic health assessment and intake assessment during the first visit with the patient.
- **Orientation Phase:** Establish a TNCR. Introduce yourself as the RN in charge of the patient's care and provide general information about the palliative care team's functions and contact information. Let the patient know the general process for requesting a visit from their palliative care RN team.
 - Obtain consent to provide nursing care and inform the patient about consent and privacy guidelines applicable to the nursing care that will be provided to them.
 - Obtain biographical data and check the patient's name, preferred way to address them, and the process for contacting them to schedule future visits.
 - Regarding subjective data, make sure to include current health status, health history, surgeries, and the list of current medications. When obtaining information about medications, ask for the containers to check any health teaching needs. Regarding medications, inquire about doctor-prescribed medications, over-the-counter and alternative med use, as well as use of recreational drugs, alcohol and smoking. Inquire about any allergies to medications and environmental triggers, including reactions upon exposure. Ask about close family health history, including surgeries.
 - Assess functional health, well-being, quality of life, and activities of daily living. Explore psychological, socio-cultural, and spiritual health, as well as coping with developmental variables' life goals. Ask the patient what is most important to them, including their concerns, challenges, and goals for the present time. Inquire about the quality of life and ask their wishes about "Do not resuscitate orders" following the health care agency protocols.
- **Working Phase:** focus on the identified current concerns and challenges for the patient. Formulate a nursing diagnosis/priority for the visit aside from doing the intake and admission to the

team's roster to help you develop a general team nursing care plan and decide potential nursing interventions. Assess potential need of services, including available support systems in the home and community. Conduct a head-to-toe physical examination to establish a baseline, and take the patient's VS. Assess support at home and family dynamics. Inquire about potential challenges for the family/significant others providing care to the patient in the home.

- **Termination Phase:** provide a summary of the visit and clarify key findings. List the areas/needs that need to be addressed by the palliative team RNs in future visits. Ask the patient if they have any questions. Reinforce length of nursing visits in future appointments and the process for contacting each other.
- **Documentation:** when the visit is over, document the visit, assessment, and data collected following agency protocols, as well as professional, ethical, and legal responsibilities of nursing practice.
- **Reporting:** When getting back to the office, provide a verbal or written report to the team following agency protocols, as well as professional, ethical, and legal responsibilities of nursing practice.
- Schedule future nursing visits for the patient following agency protocols.

CHAPTER 5: COMPLEX COMMUNICATION IN NURSING PRACTICE

Chapter Overview



- 5.0 Learning Objectives
- 5.1 Chapter Introduction
- 5.2 Developmental Considerations
- 5.3 Language Barriers
- 5.4 Auditory & Visual Challenges
- 5.5 Cognitive Challenges
- 5.6 Emotionally Challenging Conversations
- 5.7 Patient and Family Conflict
- 5.8 Conflict When Dealing with Colleagues
- 5.9 Chapter Summary

5.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Identify the impact of developmental variables on communication with patients, including potential nursing interventions to address needs.
2. Explain how linguistic discordance affects communication.
3. Identify ways to address language barriers effectively
4. Describe the origin of cognitive disorders.
5. Demonstrate effective nursing interventions to support and communicate with patients.
6. Examine factors that affect patients' communication and
7. Identify nursing interventions that support a patient's ability to express their needs.
8. Analyze causes of conflict in health care interactions.
9. Apply strategies for constructive conflict management to enhance professional growth.

5.1 Chapter Introduction

Nurses must communicate therapeutically and effectively with patients to establish a TNCR and assess health challenges accurately. Doing so requires that the nurse is aware of the impact of various factors that can make communicating with patients more challenging. These include the patient's developmental considerations and any language barriers due to language discordance. Auditory and visual deficits, cognitive disorders, intellectual impairment, hallucinations, delusions, and dementias can also lead to many challenges when communicating with patients. Substance use, high emotions, as well as violence and trauma experienced by patients, can impact their ability to express themselves in negative ways. Any conflict that occurs with patients and their family members, or that impacts the working relationship with health care colleagues, will negatively affect the TNCR and the ability to communicate professionally in a caring and compassionate manner unless the nurse remains self-aware and is able to uphold professional, ethical, legal, and organizational responsibilities.



What would you do and say as the nurse?

On your weekend night shift, you are assigned to care for a 90-year-old diagnosed with emphysema and congestive heart problems. The patient has started to deteriorate and has signed a Do Not Resuscitate (DNR) order. The physician has informed the patient that their condition is deteriorating and that they will be kept as comfortable as possible, in accordance with their wishes. The power of attorney and close family members have been updated about their loved one's status. The treatment priority and plan of care are focused on keeping the patient free of pain and as comfortable as possible. The patient remains conscious and is starting to have problems breathing. They are using oxygen via nasal prongs and deny any pain or discomfort at present. When you walk into the patient's room, introduce yourself, start to assess them, and ask how they feel, the patient asks you, "when will it happen?"

5.2 Developmental Considerations

A person's age needs to be considered when conducting the client interview. Most importantly, you need to consider a client's *developmental stage*. Developmental stage does not always align with a client's chronological age. With regard to communication, a focus on developmental stage includes attention to areas such as language and cognitive and socio-emotional development. At times, you may need to modify your communication so that you are appropriately engaging with the client at a level they understand.

There are many ways to construct chronological age categories. Broadly, children are considered anyone under 18, and adults are considered anyone 18 and older. More specifically, you could consider the categories used in this resource:

- Newborns and neonates: newborns are birth to a few hours old, and neonates are up to 28 day.
- Young children: clients who are 5 years and younger, including infants (28 days to 1 year), toddlers (1–2 years), and preschoolers (3–5 years).
- Older children and adolescents: clients who are 6–17 years, including older children/school-age children (6–12 years) and adolescents (13–17 years).
- Adults and older adults: clients who are 18 years and older, including adults (18 years and older) and older adults (65 years and older).

See *Film Clip 5.2* of an expert pediatric nurse speaking about how communication varies between children and adults.



Watch: Communication Between Children and Adults

Film Clip 5.2: Interview with an expert pediatric nurse. *Captions unavailable for this video.*

Transcript

Interviewer: How does communication differ when working with children compared with adults?

Pediatric registered nurse: When communicating with children, it is important to remember that you are often communicating with both the child and the caregiver. The caregiver may provide a lot of the information, but the child should still be included in the conversation whenever possible.

Pediatric registered nurse: I try to speak directly to the child and acknowledge them as the patient. Even if the caregiver is answering most of the questions, the child should feel seen, respected, and included.

Pediatric registered nurse: It is also important to consider the child's developmental stage. A child's developmental stage may not always match their chronological age, especially if they are anxious, ill, in pain, or in an unfamiliar healthcare environment.

Pediatric registered nurse: Nurses need to adapt their language and approach based on the child's level of understanding. This may mean using simple words, shorter explanations, visual supports, play, or demonstrations to help the child understand what is happening.

Pediatric registered nurse: Children may also need time to become comfortable. They may be frightened or hesitant at first, so it is important to be patient, calm, and reassuring.

Pediatric registered nurse: Offering choices can help children feel more in control. For example, you might ask which arm they would like you to use for a blood pressure check, or whether they would like to sit on the bed or on a caregiver's lap. These choices should be appropriate and realistic, while still allowing the nurse to complete the required assessment or care.

Interviewer: How do you adjust communication for different developmental stages?

Pediatric registered nurse: With younger children, communication often needs to be concrete and simple. They may not understand abstract explanations, so it can help to show them the equipment before using it or explain what they may see, hear, or feel.

Pediatric registered nurse: For example, if you are using a stethoscope, you might let the child look at it or touch it first. This can make the experience less intimidating and help build trust.

Pediatric registered nurse: It is important to be honest with children. If something might be uncomfortable, the nurse should not say that it will not hurt. Instead, the nurse can explain what the child might feel and offer support, comfort, or distraction.

Pediatric registered nurse: With older children and adolescents, communication should support their growing independence. They should be spoken to directly and given opportunities to answer questions for themselves.

Pediatric registered nurse: Adolescents may also need privacy, especially when discussing sensitive topics. The nurse may need to ask the caregiver to step out for part of the conversation so the adolescent can speak openly.

Pediatric registered nurse: At the same time, the nurse should explain the limits of confidentiality, especially if there are concerns about safety, harm, abuse, or neglect.

Interviewer: What role do caregivers play in pediatric communication?

Pediatric registered nurse: Caregivers are very important in pediatric care. They often know the child best and can help the nurse understand the child's usual behaviour, communication style, routines, fears, and needs.

Pediatric registered nurse: Caregivers can also help comfort and support the child during the assessment or procedure. When caregivers understand what is happening, they are often better able to help the child feel calm and safe.

Pediatric registered nurse: Overall, communication with children requires flexibility. Nurses need to adapt their words, tone, body language, explanations, and level of caregiver involvement based on the child, the caregiver, and the situation.

Age Category Communicating Skills

The following sections provide tips on broad chronological age categories, including young children, older children and adolescents, and adults, including older adults.

5.2.1 Young Children

You should use a *combination of verbal and non-verbal communication* with infants. Be *constantly aware and adapt* your use and choice of communication strategies based on the infant's response.



Figure 5.2.1: Young Children. Image: “Sleeping-baby.jpg” by Stephanie Pratt, Wikimedia Commons. CC0 1.0.

Most infants *enjoy hearing the human voice*, and this is how they learn and make sense of language. You should talk to them in a relaxed, pleasant tone of voice, even though they cannot respond verbally. It’s also okay to use *baby talk* with infants, as it can help with language development: baby talk is a type of speaking where you use enhanced vocal intonation and hyperarticulation of sounds such as vowels and consonants.

In terms of *non-verbal communication*, you should maintain a relaxed posture, smile, make appropriate eye contact, and use gestures with your hands; these techniques are important with all children because non-verbal language can facilitate their sense of safety.

When communicating with children, you should *adapt your communication to their developmental stage*. Tailor your language to a level that children will understand, avoiding long, complex sentences and instead using short sentences with simple words. Although you may use baby talk with infants, you should use a different approach with toddlers, who often want to be included in the conversation. As children get older, they enjoy receiving compliments and encouragement to connect with them (e.g., “look how much you have grown” or “great job!”).

Because *care partners* (typically parents) are often present with young children, it’s important to involve them to help the child feel safe. Here are some points to consider with care partners:

- While communicating with a parent, the infant or toddler may sit on their parent’s lap and/or play with a toy. This introductory communication can help the child get familiar and comfortable with you, particu-

larly at the first meeting.

- Children may behave differently because they are afraid or not feeling well. For example, they may hide behind the care partner, refuse care from the healthcare provider or cry or scream. These behaviours can create stress for the care partners, so it's important to be patient and demonstrate unconditional positive regard.
- Some or all of the client interviews will be conducted with the care partner when the child is unable to speak or fully articulate. Because care partners are considered a secondary source of data, you should ask them to clarify and elaborate on how they know what they are sharing with you. For example, if they say that their baby is in pain, ask how they know this.
- At times during the interview, it may be appropriate to interview the parent without the child present, particularly when talking about sensitive topics.



Activity: Test Your Understanding

Text Description

If the child is unable to speak, an interview is conducted with the ____.

It is important to adapt communication techniques to the child's ____.

Solution:

If the child is unable to speak, an interview is conducted with the **care partner**.

It is important to adapt communication techniques to the child's **developmental stage**.

5.2.2 Older Children and Adolescents

Older children and adolescents are usually at a stage where they can *participate more actively in the client interview* and articulate their experiences, emotions, and needs. Thus, it is important to *address them as the client, rather than as the care partner*. Care partners are often still involved, but you should offer the child/adolescent the opportunity to speak with you privately at times. For example, you might say to the client: "At this age, I often like to provide time to speak with you alone. Are you okay if I ask your mom or your dad to step out for a few minutes?"

You should continue to use a *combination of nonverbal and verbal* communication strategies. In non-verbal communication, make eye contact with a relaxed, open posture that shows interest in what they are saying. Smiling may be appropriate depending on the topic. You should also facilitate the interview using strategies such as nodding and statements that encourage the client to continue sharing (e.g., "uh-huh" and "tell me more"). Be aware of your facial expression and vocal intonation to convey empathy, acceptance, and a non-judgmental attitude. You may want to include fun objects or games, or include the child in the assessment process (e.g., "Would you like to try tapping on your own knee with this reflex hammer?").

Adolescents are in a transitional stage, still children but moving closer to adulthood. It is important to recog-

nize and respect their self-determination. Additionally, emotional and cognitive capacity will vary from adolescent to adolescent and from situation to situation. Therefore, your *communication strategies will need to shift* based on the adolescent and the situation. Overall, you should convey acceptance, honesty, and respect. Avoid talking to them as a child, as this is often interpreted as demeaning. Some adolescents are old enough to make their own decisions regarding some aspects of their health care: in many jurisdictions, this capacity to consent, which includes understanding and weighing risks and benefits, is determined by maturity rather than age.



Figure 5.2.2: Adolescent patient and caregivers consulting with a healthcare provider. Image: “Doctor consults with family (2).jpg” by Rhoda Baer, National Cancer Institute, Wikimedia Commons, Public domain.

When discussing sensitive and intimate topics, it is important to recognize that adolescents often feel self-conscious, embarrassed, and fearful of being judged. Your communication strategies should *convey acceptance and understanding* of what they are experiencing. You should adopt an *open, non-judgmental attitude* to cultivate a trusting relationship with the client. Permission statements can be particularly useful as they can help normalize what an adolescent may be experiencing.



Activity: Test Your Understanding

Text Description

What communication strategies are effective when assessing older children and adolescents? **Select all that apply.**

- a. Use appropriate eye contact.
- b. Use strategies that convey acceptance.
- c. Treat them as adults.
- d. Acknowledge what the client is experiencing.
- e. Use verbal and non-verbal communication strategies.
- f. Ensure the care partner stays for the entire interview.

Solution:

Correct answer(s): a. Use appropriate eye contact.; b. Use strategies that convey acceptance.; d.

Acknowledge what the client is experiencing.; e. Use verbal and non-verbal communication strategies.;

5.2.3 Adults and Older Adults

Adulthood is a *broad age category that includes everyone 18 years and older*, but there is great diversity within this group. Some adults will have had minimal encounters with nurses, and others will have had extensive encounters. Younger adults in their late teenage years and early twenties may share characteristics with adolescents, so you may use many of the same communication strategies. You should also examine and acknowledge your own biases and tendencies to stereotype older adults and constantly reassess your own assumptions so that they do not negatively affect your communication.



Figure 5.2.3: Woman receiving an intramuscular injection from a nurse. Image: “ID:C9412-DC Public Health Image Library (PHIL)”, by CDC/Judy Schmidt, Public domain.

With older adults, it is important to *give them time to process* and answer questions, as they may have a slower response time. *Avoid making assumptions* about their hearing, vision or cognitive capacity. Rather, speak in a clear voice and face them as you would with all clients. It can be helpful to write down instructions or educational information for older adults, as they often encounter substantial amounts of health information.

Some older adults may have a *care partner present* with them because they are managing multiple illnesses and may have cognitive or physical impairments that cause disabilities. When a care partner is present, you should engage in an *inclusive communication* approach. After engaging in the introductory phase with the client, ask about who the person with the client is. If appropriate, you should consider the client and care partner as a dyad in which both are recipients of care, but the client should be your main focus during your assessment. Avoid assuming that care partners can better answer questions for older clients. For example, direct your questions to the client, even though the care partner may help answer some of them.



Activity: Test Your Understanding

Text Description

What are important communication techniques for the nurse to use when speaking with older adults?

Select all that apply.

- a. Speak in a much louder tone of voice, as most elderly have hearing impairments.
- b. Consider the client and care partner as a dyad.
- c. Give time for responses.
- d. Allow the care partner to answer if the client's response time is slow.
- e. Avoid assumptions about hearing or vision capacity.

Solution:

Correct answer(s): b. Consider the client and care partner as a dyad.; c. Give time for responses.; e. Avoid assumptions about hearing or vision capacity;



Watch: On Erikson and Maslow for Healthcare

Erikson's Stages of Development Explained for Healthcare

Video: "Erikson's Stages of Development Explained for Healthcare" by WisTech Open | Open RN [4:05] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Understanding Maslow's Hierarchy of Needs in Healthcare

Video: "Understanding Maslow's Hierarchy of Needs in Healthcare" by WisTech Open | Open RN [3:35] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

You are a public health nurse providing postpartum care to new moms and their babies at home after discharge from the hospital.

What might be your nursing priorities when visiting a new mom and her baby?

Video: Family 411 – Postpartum Care

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5.3 Language Barriers

Effective communication requires a clear understanding between the people involved. Nurses provide care to individuals facing health challenges that leave them vulnerable. Therapeutic and professional communication help the nurse to understand their patients' needs and communicate effectively. However, when patients with health challenges do not fluently speak the same language as the nurse and health care team, language discordance can lead to misunderstandings, inaccurate diagnoses, and an inability to understand and relate to patients.

It is important to remember that the nurse must apply the same TNCR principles while being aware of the language discordance, including personal and professional biases. The nurse must be careful to use appropriate means of language translation and avoid assuming there is a clear understanding of what is communicated. Ideally, professional translators should be involved in following professional, ethical, legal, and organizational responsibilities. Unfortunately, due to limited resources and a lack of trust, patients may insist that family members or friends serve as translators. Nurses must remember to uphold privacy and confidentiality guidelines when using translators, and to ensure that the translator understands their responsibilities. It is not appropriate or ethical to allow children and adolescents to translate, given the developmental, sociocultural, and legal implications for placing children and adolescents in such situations.

Language Discordance

There will be times when you, the client and/or family *do not speak the same language*. In this case, you need to carefully assess and evaluate their understanding.



Language Discordance Strategies

Here are some strategies to address language discordance:

- Speak directly to the client using simple language (no jargon, no medical language).
- Be aware of your non-verbal language and consider how gestures may help the client understand what you are trying to communicate.
- Use pictures and/or have a paper and pen for them to write down notes and questions.
- Consider how best to incorporate the care partner into conversations if they speak the same language as you, but the client does not. Care partners can be an integral part of the care processes and may be constantly translating what is going on for their loved one. Thus, in everyday communication, you may consider engaging the care partner in interpreting for you and the client. For example, it may be appropriate to ask them to interpret when introducing yourself and asking the client about benign and less sensitive topics (e.g., “Are you hungry?” “Can you sit up?”).
- However, sometimes the use of an interpreter is needed. Many healthcare institutions have access to interpretation services, but these can be expensive. You may also have professional colleagues who are trained in the ethics of interpretation and can help.
- Consider using a translating app such as Google Translate that can help you translate one language into another. Although you may not speak the other language, you can show the written translation to the client so that they can read it. Additionally, the client can also type concerns, responses to your questions, and their own questions into the translating app.



Watch: On Language

More Than Words: Language Barriers in Medicine

Video: “More Than Words: Language Barriers in Medicine” by RWJF [3:47] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Effective Communication with a Medical Interpreter

Video: “Healthcare Providers: 3 tips and tricks for effective communication with a medical interpreter” by Connecting Cultures Healthcare Interpreters [8:48] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Medical Interpreter Examples

Video: “Medical Interpreter Examples” by UMN Global Medicine [10:03] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

Watch the scenario below.

What would you do to assist the patient? As you reflect on your nursing interventions, examine your rationales to help you ensure you are applying the applicable theory and meeting professional, ethical, legal, and organizational nursing responsibilities.

Video: Nursing Students Face Language Barrier Obstacle

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5.4 Auditory & Visual Challenges

You can inquire about any hearing or visual impairment and what is best for the client regarding communication. For people with hearing and visual impairments, begin by minimizing background noise and distractions. You should speak in a clear, slightly louder voice, steady tone with a deeper pitch. Avoid shouting and using a high pitch, as this can distort sound and make your words harder to hear. You should face the client directly and clearly articulate your words so that they can read your lips and attend to non-verbal cues as necessary. If the client has an assistive device (e.g., glasses or a hearing aid), ensure they have access to it.

Strategies for Communicating with Clients with Impaired Hearing and Vision

For a list of strategies, see *Appendix C1: Impaired Hearing and Vision Strategies* in this text for more information.



Watch: On Visual Impairment Support

Caring for Visually Impaired People in a Hospital

Video: “Caring for visually impaired people in hospital – SENGGENE and ERN-EYE” by DOWiNO [3:16] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Mealtime Tips for Visually Impaired Seniors

Video: “Caring Carrie: Mealtime Tips for Visually Impaired Seniors” by Home Instead – Madison, WI [3:04] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

Watch the scenario below, then watch the improved care patient scenario and compare it to your plan.

What would you do to assist the patient? As you reflect on your nursing interventions, examine your rationales to help you ensure you are applying the applicable theory and meeting professional, ethical, legal, and organizational nursing responsibilities.

1. **Video Scenario 1:** Nursing Care of an Older Adult who is Hard of Hearing
Improved Care: Nursing Care of an Older Adult who is Hard of Hearing
2. **Video Scenario 2:** Nursing Care of an Older Adult with Vision Impairment
Improved Care: Nursing Care of an Older Adult with Vision Impairment

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5.5 Cognitive Challenges

Individuals may be unable to communicate due to cognitive disorders resulting from pathology, surgery, or injury. They may have intellectual impairments that affect comprehension and expression. Due to psychiatric disorders, medications, and various forms of pathology, they may experience hallucinations and delusions. Dementia is an umbrella term for a decline in mental activity caused by changes in the brain following pathology. It is important to know and remember that dementia is not a normal part of aging. Individuals with substance use disorders experience communication difficulties due to the effect of the specific substance on brain functioning.

5.5.1 Cognitive Disorders

Clients with communication disorders related to *cognitive deficits* require additional strategies to ensure effective communication. For example, *aphasia* is a communication disorder resulting from damage to brain regions responsible for language. Aphasia usually occurs suddenly, often following a stroke or head injury, and impairs the client's expression and understanding of language. *Expressive aphasia* refers to difficulty putting thoughts into words. The client may cognitively know what they want to say, but are unable to express their thoughts. *Receptive aphasia* refers to difficulty understanding what is being communicated. The client may be able to verbalize their thoughts and feelings, but does not understand what is spoken to them. *Global aphasia* is caused by injuries to multiple language-processing areas of the brain, including those known as Wernicke's and Broca's areas. These brain areas are particularly important for understanding spoken language, accessing vocabulary, using grammar, and producing words and sentences. Individuals with global aphasia may be unable to say even a few words or may repeat the same words or phrases over and over again. They may have trouble understanding even simple words and sentences (NIDCD, 2025).

The most common type of aphasia is *Broca's aphasia*. People with Broca's aphasia often understand speech and know what they want to say, but often speak in short phrases that require great effort. For example, they may intend to say, "I would like to go to the bathroom," but instead the words, "Bathroom, Go," are expressed. They are often aware of their difficulties and can become easily frustrated. See the box below for evidence-based strategies to enhance communication with a person with impaired speech.

Link to Learning

Read more about aphasia.

Strategies to Improve Communication with Clients with Impaired Speech

For a list of strategies, see *Appendix C2: Strategies for Clients with Impaired Speech* in this text for more information.



Watch: On Cognitive Disorder Communication

Communication with Cognitive Communication Disorders

Video: “Best Way to Communicate with Dementia Patients – Doctor’s Advice” by SingHealth [3:31] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Communication Strategies for Aphasia Patients

Video: “Communication Strategies for Aphasia Patients” by County Durham & Darlington NHS Foundation Trust [5:26] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.5.2 Intellectual Impairment

Some of your clients will have *intellectual or cognitive impairments* that may result in disabilities affecting their ability to learn and reason (e.g., Down syndrome, fetal alcohol syndrome). You should *consider how each client can best participate in communication* (e.g., listening, talking, understanding and processing information). You should engage in active listening and determine what is important to the client. Speak clearly and ask simple questions. Speak in a positive tone with a steady pace and avoid speaking slower, as this can come across as patronizing. You may encourage them to bring someone with them that they trust, such as a care partner; you should still focus your attention on the client, but also create an inclusive space for the care partner to be involved.



Watch: Best Practices: Frequent Visitors

Video: “DD CARES Best Practices: Frequent visitors” by CAMH Education [6:10] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.5.3 Hallucinations

Due to psychiatric disorders, various pathologies, medications, and brain injury, people can have sensory experiences that may appear real. They can hear, see, touch-feel, smell, and taste things that are not real and are only created by their minds. Hallucinations can be auditory, visual, tactile, olfactory, and gustatory.



Watch: On Hallucinations

Video: “Do This, Not That! Providing Care for Medical Patients with Psychiatric Issues: Hallucinations” by BJC HealthCare [9:47] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.5.4 Delusions

Due to psychiatric disorders and neurological conditions, people can hold fixed beliefs that are not true, cannot be reasoned with, and represent a disturbance of their thought processes (Mental Health America, n.d.). Delusions may cause harm to the individual and others. Types of delusions include persecutory, grandiose, somatic, erotomanic, and nihilistic (WebMD, 2024).



Watch: On Delusions

Video: “Do This, Not That! Providing Care for Medical Patients with Psychiatric Issues: Delusions” by BJC HealthCare [9:37] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.5.5 Dementia

Dementia is a general term for loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life. Alzheimer’s is the most common cause of dementia (Alzheimer’s Association, n.d.).



Watch: On Dementia

Simulation Scenario – Dementia Care Refusal

Video: “Simulation Scenario – Dementia Care Refusal” by Western Australian Clinical Training Network [6:57] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Tips On How To Calm Down Someone Who Has Dementia

Video: “Tips On How To Calm Down Someone Who Has Dementia” by Senior Safety Advice [4:29] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.5.6 Substance Use

A client under the influence of drugs and substances (alcohol, cannabis, prescribed medications, and/or illegal street drugs) can have an altered capacity to think, reason, and communicate. Although some of these substances may be illegal and non-prescribed, it is important to maintain a *non-judgmental attitude* and *convey unconditional positive regard*. As a nurse, it is not your job to judge a client. Rather, you should use a relational inquiry approach to understand the circumstances that have influenced their choices and respect that each client has agency and self-determination.

While the client is under the influence of a substance, use communication strategies that facilitate their capacity to understand what you are saying and communicate with you while maintaining safety. Thus, you should speak clearly and in short simple sentences. Focus on the reason for seeking care or the priority issue. There will be time for a collaborative discussion and health promotion after the effects of the substances have dissipated.



Watch: Opioid Withdrawal Scenario

Video: “Nursing Simulation Scenario: Opioid Withdrawal” by Montgomery College [7:17] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activity: Test Your Understanding

Text Description

A young adult client is admitted to a psychiatric unit. The client is agitated and has a history of being violent. What communication techniques should the nurse use when approaching the client? **Select all that apply.**

- a. Introduce yourself to the client.
- b. Speak loudly to maintain control of the situation.
- c. Engage in active listening.
- d. Call for help if the client becomes aggressive.
- e. Do not act afraid.

Solution:

Correct answer(s): a. Introduce yourself to the client.; c. Engage in active listening.; d. Call for help if the client becomes aggressive.; e. Do not act afraid.;

From Theory to Practice

You have been assigned to care for a patient who is diagnosed with dementia. They insist they want to go home because their daughter is waiting for them. What would you do to assist the patient? Watch the scenario below

As you reflect on potential nursing interventions, examine your rationales to help you ensure you are applying the applicable theory and meeting professional, ethical, legal, and organizational nursing responsibilities.

Video: Working With Dementia (3 of 4)

The section on *Cognitive Disorders (5.5.1 to 5.5.6)* has been adapted from “Additional Considerations,” in *Introduction to Communication in Nursing* Copyright ©2020, edited by Jennifer Lapum, Oona St-Amant, Michelle Hughes, and Joy Garmaise-Yee, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted. *Modifications: select chapter information has been used and edited for conciseness.*

5.6 Emotionally Challenging Conversations

Nurses provide care and interact with patients who are dealing with health challenges that cause them to feel very vulnerable. Nurses must therefore help patients understand, problem-solve, and manage very difficult situations that may not have a positive or desired outlook. Patients must identify and deal with emotions to be able to manage, cope, and grow from the unexpected challenges and trauma they face.

5.6.1 Emotions

Clients commonly experience sadness, anger, fear, anxiety, embarrassment, and other *emotional responses* in the context of health and illness. It is important that you cultivate a therapeutic environment where clients feel comfortable opening up about their emotions. Open-ended questions like “Tell me about how you are feeling” can facilitate discussions about a client’s emotional response. Additionally, you might consider using permission statements to help normalize how the client is feeling and provide an opening for them to speak about emotions. For example, “Clients often experience sadness or anger when they are diagnosed, how are you feeling?”

It is important that you *acknowledge the client’s emotions* and provide space for them to experience them. Avoid changing topics. Give the client time to voice their emotions or even cry. Using silence and active listening are effective communication strategies during these circumstances.



Watch: Terminal Diagnosis Conversations

Video: “Ep. 25 How Do I Talk to Someone with a Terminal Diagnosis?” by Cancer Chats [7:30] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.6.2 Violence and Trauma

Many clients will have experienced *violence and trauma* in their lives, such as abuse, bullying, grief or loss of a loved one, or natural disasters or war. You will often not even be aware that they have experienced violence or trauma, so it’s best to use a *trauma-informed approach with all clients*, as discussed in Chapter 1. Because you might not know if a client has experienced trauma, it is best to approach all clients with the assumption that they may have experienced violence and trauma at some point in their lives. Reflect on how best to help them feel safe and provide them as much choice and control in the clinical encounter as possible.

Some communication strategies that are consistent with a trauma-informed approach include:

- Introducing who you are and why you are there.

- Explaining each step of what you are doing.
- Asking permission to touch.
- Give the client options on what topic to discuss first.

From Theory to Practice

Watch the scenario below.

As you reflect on the nurse's therapeutic communication skills, consider how she is meeting professional, ethical, legal, and organizational nursing responsibilities..

Video: Suicide Risk Assessment in Youth

The sections on Emotions and Violence (5.6.1 & 5.6.2) have been adapted from "Additional Considerations," in Introduction to Communication in Nursing Copyright ©2020, edited by Jennifer Lapum, Oona St-Amant, Michelle Hughes, and Joy Garmaise-Yee, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted. *Modifications: select chapter information has been used and edited for conciseness.*

5.7 Patient and Family Conflict

A Positive Lens of Conflict

■ *Conflict is a variance in perceptions and opinions that involves a perceived or actual threat.*

It is important to avoid thinking of a threat as an intention to inflict physical harm or pain upon someone. Rather, consider a threat as an unfavourable situation and a force that may adversely affect you.

Threat is embedded in *conflict* because a person's perception or position quickly becomes part of who they are (i.e., their self-concept) and, as such, an opposition to this perception is considered "a threat to self" (De Dreu & Van Knippenberg, 2005). A perceived threat or an actual threat happens with conflict because you perceive that something/someone is challenging your beliefs or needs and may affect your sense of self or the relationship you have with them.

Have you ever perceived a threat when having a difference of opinion or disagreed with someone else? Have you felt a sense of threat in a setting where there are deeply ingrained power dynamics? Have you been engaged in a class discussion where you had a different way of seeing things than another person? Have you had a concern about a university/school's policy? Have you received a grade on a paper from a professor and you did not agree with it? You may feel worried to speak up about an issue because the other person has a different perspective from you. You may fear that if you speak up, they will think you are ignorant or that it may affect your relationship with them. These are all examples of conflict and are associated with a perceived threat or actual threat.

■ *Conflict can trigger strong emotions and negatively affect how you respond and communicate.*

Consider how you have responded to conflict in the past. Did you ignore or avoid the conflict? Did you take the disagreement personally? Did you engage in an intense and relentless argument? Have you ever not addressed it with the person, but instead posted on social media or gossiped to a friend or peer? These are all ineffective ways to deal with conflict because it never resolves the problem – the conflict.

It is important to understand and address conflict as it is a part of any relationship, including those in the educational and professional settings. There is the possibility of transforming how you perceive and address conflict – this is the positive lens of conflict.

Points of Consideration

The positive lens of conflict

A starting point is to transform how you view conflict. Have you ever considered viewing conflict from a positive lens? Conflict suggests that you have an opinion that you hold as meaningful or important. In itself,

this is a good thing. It can be beneficial to approach conflict as an opportunity to promote healthy working relationships and ultimately, promote optimal client outcomes. You can learn and grow by truly listening to another person's view and sharing your own. Part of this is seeking to understand what the perceived threat is for you and for the other person(s). This involves reflecting on your own values and beliefs related to the topic of the conflict. Then, put yourself in the other person's shoes and attempt to understand their perspective.

You should engage in a professional and open conversation in which both parties share their perspective. If approached professionally, this sharing can help you feel good that you have shared your opinion, why it matters to you, and participated collaboratively and respectfully to manage the conflict. Additionally, by learning and growing while engaging professionally with another person, this can sometimes create a connection that cultivates your relationship with them. It can also add to a positive resolution related to the conflict with the potential for creative and divergent thinking.

5.7.1 Anger and De-escalation of Patients

Communication is a particularly important strategy to use when your purpose is to *de-escalate a situation*. Escalation can occur in any healthcare situation when clients are encountering intense emotions and experiences entangled with stress, fear, anger, uncertainty, pain, and lack of control. This can lead to the client spiralling out of control, agitation, aggression, and even violence. Contextual factors may include clients who have received bad news, such as a diagnosis, clients who are under the influence, and/or clients who are having a mental health crisis. *Attend to your own safety* and be aware of the potential risk factors. It is important to notify a colleague(s) when interviewing a client who is at risk of, or has a history of, escalating.



De-escalation Strategies

De-escalation includes ways to reduce and/or prevent escalation. De-escalating communication strategies include:

- Acknowledge and value how the client feels and be non-judgmental.
- Avoid downplaying or judging how the client feels.
- Engage in active listening to understand the situation and explore the reason for the escalation.
- Offer genuine interest, concern, and empathy.
- Remain calm and do not allow your voice or non-verbal communications to demonstrate rising emotions.
- Recognize the client's self-determination and collaborate with them on how to address the issue.
- Maintain your safety, but do not act afraid.
- Maintain your professionalism and do not take the situation personally.



Watch: Calming & De-escalation Strategies

Video: “Calming & De-escalation Strategies” by Dartmouth Trauma Interventions Research Center [4:22] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

5.7.2 Inappropriate Communication from Patients and Their Families

There will be times when clients engage in inappropriate communication. This kind of communication may include *verbal and non-verbal language* such as inappropriate physical touch, violent or aggressive behaviour, harassing language (e.g., name-calling, threats), and sexualized language. As a nurse, you should *rely on the CNO (2025a) practice standard* about the therapeutic nurse-client relationship. Keep in mind that all client behaviour has meaning and that you should aim to understand it (CNO, 2025a).



Strategies for Inappropriate Client Language

Consider these strategies when responding to inappropriate client language:

- If applicable, ensure your personal safety. Depending on the situation, this may involve moving toward the doorway or having it in your sight, leaving the room, or calling for help.
- Acknowledge the language/behaviour and clearly let the client know that it is inappropriate, do so in a professional and non-judgmental manner.
- Remind the client that, as a nurse, you only engage in professional relationships with clients and families.
- Ask the client if their language has something to do with the effects of their health or illness.



Watch:

Dealing with a Patient's Rude Family Members

Video: "Dealing with a Patient's Rude Family Members | New Nurse Tips | Nurse Vlog" by RegisteredNurseRN [9:16] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

This Patient is Racist (or Sexist). Now What?

Video: "This Patient is Racist (or Sexist). Now What? – Medpage Today" by MedPage Today [5:53] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

From Theory to Practice

Watch the scenario below.

What would you do to assist the patient and colleagues in the room? As you reflect on your nursing interventions, reflect on your rationales to help you ensure you are applying the applicable theory and meeting professional, ethical, legal, and organizational nursing responsibilities.

Video: Agitated Patient Scenario – Simulation Center | NCH Healthcare System

The sections on *A Positive Lens of Conflict*, *Anger and De-escalation* and *Inappropriate Communication* (5.7.1 & 5.7.2) have been adapted from "A Positive Lens of Conflict," and "Additional Considerations," in *Introduction to Communication in Nursing* Copyright ©2020, edited by Jennifer Lapum, Oona St-Amant, Michelle Hughes, and Joy Garmaise-Yee, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted. *Modifications: select chapter information has been used and edited for conciseness.*

5.8 Conflict When Dealing with Colleagues

Conflict Defined

Conflict can be defined as a state of serious opposition between two or more perspectives that influences thinking and actions. For example, people may disagree because they have different perspectives.

However, varying perspectives alone do not lead to conflict: conflict arises when one individual's behaviours impede another's interests or goals, resulting in negative emotions such as fear, anger, and frustration (Barki & Hartwick, 2004, as cited in RNAO, 2006).

Different perspectives will inevitably arise in any context, whether it is at work, with friends, or with colleagues. In an interprofessional environment, different perspectives will occur even when communication is relatively good. For example, healthcare professionals may have *different disciplinary perspectives* that inform their understanding of a situation, and may have different priorities in terms of client care. Communication can become problematic when these perspectives and priorities contradict one another. Conflict is also more likely if interprofessional communication is sub-optimal and ineffective. Other factors that may contribute to conflict include lack of respect for others' perspectives, and differences in values, age, gender, education, ethnicity and culture, as well as elements related to professional roles such as responsibilities, power, and scope of practice (RNAO, 2012).

Consider the following strategies to prevent or manage conflict:

First

Use a *client-centred approach*. This ensures the focus is on the client as a whole person and that the patient is cared for in ways that respect their “autonomy, voice, self-determination, and participation” in their own care (RNAO, 2006).

Second

Use an *evidence-informed approach*. This will help you critically engage in discussions that are informed by the evidence, rather than personal preference. In addition, an evidence-informed approach can help to facilitate the professional growth of other members of the intraprofessional and interprofessional team by introducing them to new research and knowledge.

Third

It is essential that you be open to hearing, respectfully discussing, and reflecting on the perspectives of all team members (Lyndon et al., 2011). In addition to sharing your perspective, share the rationale for it. Along with a client-centred and evidence-informed approach, this kind of effective dialogue will benefit the person who is the focus of care and decisions: the client.

Points of Consideration

Interprofessional communication can be optimized using a client-centred perspective and an evidence-informed approach. It should be guided by discussions that are centred on the client's wellbeing and incorporate the best possible evidence for each client.

Preventing and managing interprofessional conflict involves responsibility at both *individual* and *systemic* levels. The interpersonal nature of conflict is important, but contextual and organizational factors can also contribute. In the context of nursing, interprofessional team members are often working in environments where they are dealing with feelings such as frustration, burnout, dissatisfaction, and a sense of being undervalued. This kind of environment requires a high level of acuity and can be very emotionally draining.

It is imperative to consider whether healthcare organizations and systems are supporting collaboration and conflict resolution, or contributing to negative emotions (RNAO, 2006). For example, are processes and systems set up for easy communication? Do teams work together, or are there divisions and hierarchies? Is there shared decision-making and accountability, or a culture of blame, disrespect, and fear of reprisal? Are certain health professionals particularly overworked? To prevent and reduce interprofessional conflict, the RNAO (2006) has developed specific recommendations for organizations to consider related to organizational structures and climate, leadership support, staffing practices, communication practices, and professional components.

5.8.1 Incivility from Co-workers

Effective *intraprofessional* (within a discipline) and *interprofessional* (across disciplines) communication and interactions are essential to effective work environments and quality and safety in healthcare. *Civility is a key component* of effective communication and interactions, and is particularly important because of the stressful and complex nature of healthcare environments and decision-making.

Civility involves treating others (e.g., healthcare team members) with respect, listening to their perspective, considering their feelings within an encounter, and respecting differences, but also working to seek common ground when needed. It is essential to emphasize that civility involves engaging in *authentic, respectful, and inclusive* ways with others; civility fosters a feeling of belonging and community even when there is conflict or differences in perspectives (Clark et al., 2022).

Incivility is a serious issue in teamwork (in both intraprofessional and interprofessional environments). Incivility within communication encounters or interactions involves the *covert* (subtle) or *overt* disrespect of another person. Examples include discourtesy, eye rolling, gossiping, rude comments, name-calling, complaining, and physical actions, including violence – all of these behaviours that can cause emotional and physical harm to a person. Conflict management strategies and communication training are known to assist nurses in deterring and addressing uncivil behaviours as well as fostering clarity and trust.

Bullying and *harassment* are often referred to as types of incivility addressed to a specific person. Although these terms are similar, harassment specifically is a type of discrimination based on factors such as religion, race, age, sex, and disability (Canadian Human Rights Commission, n.d.). Bullying and harassment are typically repetitive behaviours (happen more than once) that harm or humiliate another person. However, they can also

include serious one-time incidents of unwanted verbal and/or physical behaviour (Canadian Human Rights Commission, n.d.).

These behaviours usually occur in the context of a real or perceived *power imbalance*. For example, the person who is bullying often thinks they have more power (e.g., more seniority, authority, specialized title/role, more education). This type of incivility may also occur between nurses as forms of *horizontal violence*, which is lateral violence within a group.

Many forms of harassment and bullying can occur within the nursing profession (intraprofessional) and across various healthcare professionals (interprofessional). They may be *physical*, such as unwelcome touching of your body or the attire you wear. More often, they take the form of *non-verbal* and *verbal behaviours*. This includes demeaning, humiliating, and belittling language, hurtful teasing/jokes, name-calling, slurs, insults, and criticism as opposed to critique. Non-verbal behaviours specifically can include eye-rolling and other facial and bodily expressions. Other bullying and harassing behaviours include ostracism and purposefully ignoring someone and not helping colleagues, or continually assigning someone workloads that are considered difficult and problematic.

Keep in mind that intraprofessional or interprofessional conflict does not constitute incivility or harassment. You will have conflict in the workplace where you have strong opposing points of view. Additionally, your supervisor or a peer may even provide feedback or constructive criticism in a supportive manner – this also does not constitute incivility or harassment. There may be uncivil behaviour in the workplace that also does not constitute harassment or bullying, but still should be addressed (Treasury Board of Canada Secretariat, 2025).

You may not readily recognize that you are being bullied or harassed, and not everyone who bullies or harasses is aware of their own behaviour. Sometimes these behaviours arise because of interprofessional conflict, but they can also be caused by personal issues. For example, healthcare team members could have stress at home, financial concerns, or anger management issues. All of these factors can affect how they engage with others in all settings, including the healthcare environment, and the stresses associated with the healthcare environment can also be contributing risk factors.

Remember

Whatever the reason, you have the right to a workplace free of any form of incivility, including bullying and harassment.

Professional nursing associations have been instrumental in addressing and managing workplace bullying and harassment. It is important for all nurses to attend to this form of violence in the workplace and take a *leadership role* in order to make a change. Nursing has a legacy as an oppressed group because of its history as a subordinated profession (i.e., being considered subservient to the medical community) and because of socio-cultural structures like nursing being deemed gendered work. Oppressed group behaviour can lead to horizontal violence, when parties in the same group lash out or exhibit violence toward each other in response to external dominant power. In such cases, members of an oppressed group feel subjugated and powerless against a dominant group and essentially take it out on each other. It is important to be aware of this dynamic as we work toward creating workplaces that are free from and intolerant to violence.

Understand Incivility, Violence, Harassment, and Bullying

So, why is it important to understand incivility, violence, harassment, and bullying? Violence, harassment, and

bullying are identified as occupational health and safety hazards that are underreported and often unrecognized (Becher & Visovsky, 2012).

As a nursing student, you need to be aware of what incivility, harassment, and bullying are and how to deal with them. These behaviours are not always conscious choices, so self-reflection and awareness are important first steps toward eliminating this type of incivility and violence in the workplace. Being the victim of bullying can have traumatic effects on self-esteem, mental health, and confidence in the workplace. Additionally, systemic bullying within an interprofessional team setting can affect staff morale, job performance, team functioning, and, importantly, client care.

Witnessing Incivility or Harassment

What should you do if you observe incivility or someone being harassed? Here are some helpful steps to take:

First

If you observe incivility, step in and support the person on the receiving end.

Second

If you feel comfortable and safe, have a discussion with the person who is demonstrating the uncivil behaviour. Avoid participating in confrontational dialogue. Engage in an inquisitive discussion to better understand why it is occurring, and, if the person understands what they are doing and its impact on the other person. For example, you might say to them, I noticed that you have repeatedly rolled your eyes and interrupted X when they were sharing their perspective. Were you aware of your behaviour?

Third

If the incivility or harassment continues, report and document the incidents to your manager and the human resources department. If it is your manager who is creating the uncivil environment or doing the harassing, human resources should be your main point of contact.

Points of Consideration

“I am a nursing student. What should I do if I believe I am experiencing incivility in the learning environment or feel that I am being harassed or bullied in my clinical placement or in school?”

First, recognize this is not your fault, and you do not deserve this. You have the right to a civil learning environment free of incivility, violence, harassment, and bullying. You deserve to be respected and supported in your learning.

Although it may not seem like it, the person who may be creating the incivility in the learning environment

or doing the bullying or harassment might not realize they are doing it, and they may not realize the impact of their actions. It is always best to speak with the person if you can. Have a private conversation and share your perspective and how you are being affected, but do so in a non-confrontational manner.

If at first you feel too intimidated to do so, consider speaking with an instructor or a trusted individual at your school or university to support you, brainstorm with you how to approach the situation, and, if needed, provide appropriate resources. In some cases, your support person may advise you to contact a senior leader in the school, counselling services, the ombudsman, or other similar resources offered by Fanshawe College. However, all colleges likely have similar resources and supports.



Watch:

How to Deal with Rude Doctors

Video: "HOW TO DEAL WITH RUDE DOCTORS" by Ashley Lorena Adkins, MSN, RN, CCRN [4:56] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

How to Deal with Rude Nurses

Video: "HOW TO DEAL WITH RUDE NURSES" by Ashley Lorena Adkins, MSN, RN, CCRN [5:10] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Nurse-to-Nurse Communication Skills

Video: "Communication in Nursing | Nurse-to-Nurse Communication Skills" by RegisteredNurseRN [5:40] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Nursing Simulation Scenario: Managing Incivility

Video: "Nursing Simulation Scenario: Managing Incivility" by Montgomery College [4:02] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activity: Test Your Understanding

Text Description

What is the first thing you should do if a colleague approaches you and confides that they are experiencing bullying?

- a. Provide them with support.
- b. Document the incident.
- c. Approach the bully on their behalf.
- d. Report it to human resources.

Solution:

Correct answer(s): a. Provide them with support.

From Theory to Practice

You are a fourth-year student nurse on a busy medicine floor. You are not very comfortable doing IVs and must ask your preceptor to help you with the IV again. Your preceptor is very busy and feeling very frustrated. They tell you, “I can’t believe you need help again. I just helped you. I’ll be there in a minute.”

What might you say and do in this situation, following professional, ethical, legal, and organizational nursing responsibilities?.

Video: Nursing Incivility

This section has been adapted from “Conflicts in an Interprofessional Environment” and “Harassment and Communication” in *Introduction to Communication in Nursing* Copyright ©2020, edited by Jennifer Lapum, Oona St-Amant, Michelle Hughes, and Joy Garmaise-Yee, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted. *Modifications: edited for conciseness and removed some images.*

5.9 Chapter Summary



Key Takeaways

Complex communication in nursing practice requires the skillful management of high-stakes, multi-layered, and emotionally charged exchanges with patients, family members, and colleagues. The nurse must establish a TNCR and use therapeutic communication skills to build trust and bridge language and cultural barriers while ensuring patient safety. Conflict experienced with patients, family members, and colleagues can become an opportunity for personal and professional growth if the nurse remains self-aware and is able to integrate their professional and therapeutic self effectively..



Knowledge Check

Quiz Text Description

1. MultiChoice Activity

Which is the best way for a nurse to assess stomach pain in a 4-year-old child?

- a. Using OLDCARTSS in the same way you would use them with any patient
- b. Summarizing to the child all the information collected from the mom
- c. Asking the child to show where their pain is located using a teddy bear
- d. By getting all the information about the pain from the mother

2. MultiChoice Activity

Which of the following is not true when providing care to a 17-year-old?

- a. Competent adolescents have the right to confidential healthcare, unless there is an imminent risk of harm to self or others
- b. Interview the patient privately and with caregivers to respect confidentiality, build trust, and ensure a holistic evaluation
- c. The information regarding sexual activity must be automatically disclosed to the parents, following the law
- d. You must always set explicit boundaries around confidentiality and its limits at the very beginning of the interview

3. MultiChoice Activity

A nurse must do a health interview with a patient who does not speak English very well. The patient smiles and says, "Your daughter he's good. He speaks for me. Is 10 years". What should the nurse do?

- a. Check the organization's process for using and getting a translator
- b. Follow the patient's request to use their daughter as a translator
- c. Check that the daughter is comfortable translating for their parent
- d. Give the daughter information about what she is expected to do

4. MultiChoice Activity

Which of the following is a good strategy for the nurse to feed a patient who does not hear or see very well?

- a. Minimize glare in the room
- b. Provide very thorough explanations before, during, and after the meal
- c. Always shout and speak loudly to ensure they hear you
- d. Ensure the room is well-lit

5. MultiChoice Activity

The nurse is helping a patient with expressive aphasia to provide information about their meal preferences. Which of the following is a good strategy to use with the patient?

- a. Ask a lot of questions so the patient has many chances to talk about their preferences
- b. Use mostly open-ended questions to get information from the patient
- c. Phrase questions so the client can answer using a simple “Yes” or “No”
- d. Reassure the client that their speech problems are normal, and they should not get upset

6. MultiChoice Activity

Following their surgery, a patient is crying because they keep seeing shadows and hearing scary voices. What should the nurse do for this patient?

- a. Call the surgeon right away to inform them their patient is in trouble
- b. Reassure the patient that they are safe because they are probably only experiencing medication side effects
- c. Check the room with the patient to show them there are no shadows, no voices, and tell them they are safe
- d. Notify the resident that the patient had a bad reaction to anesthesia

7. MultiChoice Activity

A 45-year-old diagnosed with Lewy-Body dementia secondary to Parkinson's who lives in a care home is screaming that they must go to work. They are demanding for the nurse to open the door so they can get in their car and drive to work. What is the best way for the nurse to assist this patient?

- a. Ask the patient if they have any pain or discomfort
- b. Reorient the patient by reminding them where they are and that is their home
- c. Tell the patient it is time to get ready to eat breakfast
- d. Remind the patient that they do not work anymore and don't have to worry

8. MultiChoice Activity

The nurse finds the patient crying following a conversation with the doctor who diagnosed them with terminal cancer. How can the nurse provide care to the patient?

- a. By quickly leaving and ensuring the patient's privacy
- b. By placing some tissues within the patient's reach, offering a glass of water, and sitting with the patient
- c. By excusing themselves for the interruption and telling the patient they will return later
- d. By walking into the room, giving the patient a big hug, and telling them you are very sorry about the news

9. MultiChoice Activity

When admitting a patient to the unit, their spouse informs the nurse that they only want to be looked after by a white nurse who speaks English well and went to nursing school in Canada. Following professional, ethical, and legal responsibilities of nurses, how should the nurse respond?

- a. By letting the patient and spouse know the specific education the nurse possesses and how long they have lived in Canada
- b. By informing the patient and spouse that discriminatory, offensive behaviour will not be tolerated if they ever want to get any nursing care in Canada
- c. By letting them know that the unit does not cater to people's whims regarding the nurses assigned to look after them
- d. By replying, politely and firmly, that all Canadian-regulated nurses are highly qualified, pass rigorous standardized examinations, and meet the exact same high safety standards

10. MultiChoice Activity

A nursing student who is not comfortable administering intravenous (IV) medications requests the help of their nurse preceptor. The RN is very busy and frustrated with the way the unit is running. The preceptor replies to the student loudly, in a short and menacing way, that they have already helped them with IVs many times, but they will go help them as soon as they can. What should the student nurse do?

- a. Walk away and pray that the nurse fixes the IV as soon as possible
- b. Thank the nurse for their help and assure them they will review how to work with IVs. Politely and respectfully let them know they realize the RN is very busy, but their response is not very helpful and supportive of the student
- c. Apologize to the nurse many times and thank them for their help
- d. Inform the nurse that they will be reported to the manager. They will also be reported to the College and the faculty advisor right away. It is their job to help students. The RN is responsible if something is wrong with the IVs

Solution:

- 1. c. Asking the child to show where their pain is located using a teddy bear
- 2. c. The information regarding sexual activity must be automatically disclosed to the parents following the law
- 3. a. Check the organization's process for using and getting a translator
- 4. a. Minimize glare in the room
- 5. c. Phrase questions so the client can answer using a simple "Yes" or "No"
- 6. c. Check the room with the patient to show them there are no shadows, no voices, and tell them they are safe
- 7. b. Reorient the patient by reminding them where they are and that is their home
- 8. b. By placing some tissues within the patient's reach, offering a glass of water, and sitting with the patient
- 9. d. By replying, politely and firmly, that all Canadian-regulated nurses are highly qualified, pass rigorous standardized examinations, and meet the exact same high safety standards
- 10. b. Thank the nurse for their help and assure them they will review how to work with IVs. Politely and respectfully let them know they realize the RN is very busy, but their response is not very helpful and supportive of the student



For Further Reflection

How will you make sure you take care of yourself as a student nurse and later as an RN? Why is it important for you to take care of yourself before you can take care of others?

- Video: “How Grief Can Enable Nurses to Endure | Hui-wen Sato | TEDxPasadena” by TEDx Talks [9:55] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

What would you do and say as the nurse?



90-year-old with Emphysema and Congestive Heart Problems: Case Study Analysis

Review the scenario

Key Points

- Establish a TNCR: introduce yourself and tell the patient you are their night nurse. Ask how they want to be addressed and tell them what you will do for them during the night. Make sure you tell them you will keep them comfortable following the physician's orders for medication. Assess pain, discomfort, breathing, and any other needs
- Clarify what they mean when the patient asks, "when will it happen?" You might say "tell me what the doctor has told you" to begin to assess and explore the patient's needs, including what they are thinking and feeling. The patient may need to know more about their condition, overall deterioration, and the process of dying. They may need to grieve, understand, and accept what is happening to their body. They may just want to be reassured and check that you know how to look after them
- You must engage in self-reflection and be aware of your feelings, biases, and thoughts in general about death and dying. You must accept your comfort and discomfort regarding the situation. To help a patient explore their impending death, a nurse must feel comfortable with death and dying, including finding more information about what they don't know, should know, must know, and ought to know to be able to assist the patient in their final journey
- It is important for you to know and understand your professional, ethical, legal, and organizational nursing responsibilities regarding the care of this patient and his loved ones
- Talking about death and dying will depend on the identified specific patient needs. If you are comfortable doing this, you will give permission to the patient and the needed support to explore their final journey as they come to terms with their life coming to an end
- At this stage, if they are conscious, patients want to know more about the death process. They want to be reassured that they will be cared for and supported in a dignified way so that they will not suffer unnecessarily
- Patients may have unresolved issues with family dynamics or life in general. By presencing and listening mindfully to the patient, the nurse can find and connect with appropriate resources, including religious leaders, counselling, and legal services to help the patient make peace with

the end of their life

- It is very important for the nurse to follow professional, ethical, legal, and organizational responsibilities regarding the documentation of the care provided, including all conversations with the patient

CHAPTER 6: ASSESSMENT AND COMMUNICATION OF VITAL SIGNS

Chapter Overview



- 6.0 Learning Objectives
- 6.1 Chapter Introduction
- 6.2 General Considerations
- 6.3 Pulses
- 6.4 Respirations
- 6.5 Oxygen Saturation
- 6.6 Blood Pressure
- 6.7 Temperature
- 6.8 Critical Thinking and Reflection Exercises
- 6.9 Chapter Summary

6.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Identify normal/expected vital sign ranges for diverse patient populations (e.g., pediatric vs. adult).
2. Explain how external factors like age, pain, stress, and medications affect baseline readings
3. Demonstrate accuracy when obtaining vital signs—temperature, pulse, respirations, blood pressure, and SpO₂—using standardized equipment and correct anatomical landmarks.
4. Observe patient deterioration by analyzing abnormal vital sign trends and differentiating between stable baseline variations and critical red flags that require urgent clinical intervention.
5. List common sources of measurement error and troubleshoot techniques to ensure the accuracy of findings.
6. Document findings to effectively communicate to the patient and health care team following professional, ethical, legal, and organizational guidelines

6.1 Chapter Introduction

There are five basic vital signs that the nurse frequently obtains to assess the patient's baseline status (Perry, Potter, & Ostendorf, 2014). Another reason for obtaining this objective data is to check how people are doing before procedures. If a patient's condition changes or deteriorates, the nurse can compare the results to the baseline parameters. When taking vital signs, it is important to always ask the patient whether they are experiencing any pain or discomfort and to use a framework such as oldcartss to assess pain appropriately.

The temperature, pulse, respiration, blood pressure (BP), and oxygen saturation are vital sign measurements that indicate a person's hemodynamic status. Vital signs can reveal sudden changes in a patient's condition and measure progressive changes over time. The difference between a patient's baseline and current vital signs may indicate the need for nursing intervention (Perry et al., 2014). Appendix 6A provides a quick summary of nursing interventions when checking vital signs.

Vital signs are typically obtained prior to performing a physical assessment. Obtaining vital signs for stable patients may be delegated to unregulated health care providers such as personal support workers (PSWs) who work under the guidance of a registered nurse. However, the nurse is always accountable for analyzing vital signs and implementing appropriate interventions for out-of-range findings. The order for obtaining vital signs depends on the patient's situation (ABC airway-breathing-circulation challenges), and the nurse's comfort with the patient following their ability to establish a TNCR. When obtaining vital signs, it is important for the nurse to communicate the findings to the patient using language that the patient can understand. Following professional, ethical, legal, and institutional responsibilities, the nurse must also document the vital signs findings as soon as possible. Nurses are also expected to report any out-of-range findings to the health care team and intervene promptly.



Watch: Taking a Patient's Vital Signs

Video: "English for Nurses: Taking a Patient's Vital Signs" by Virginia Allum [2:19] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



What would you do and say as the nurse?

Your patient is 45 years old, newly married, and very worried about the future. They were recently diagnosed with amyotrophic lateral sclerosis (ALS). The patient complains of muscle twitching and cramping of the limbs, as well as weakness. Denies any pain but sometimes experiences speech and swallowing difficulties. The

patient and their spouse are visiting the clinic. They want to get checked and are anxious about how the disease is progressing. The patient tells you, "Please check me out and tell me if the numbers are bad."

6.2 General Considerations

Appendix Resource: Checklist

See Appendices D1: Vital Signs Checklist I and D2: Vital Signs Checklist II, which outline the steps to take when checking vital signs.

Therapeutic Environment and Informed Consent

It is important to obtain informed consent while creating a therapeutic, safe environment during all encounters with clients. You will usually begin by introducing yourself by *name* and *designation* so the client knows who you are. Next, explain what you are going to do and always ask permission to touch before beginning vital sign measurement.



Introductions: An Example

An example of an appropriate introduction is as follows:

"Hello, I am XXX (state first and last name). I am a XXX (state designation, e.g., I am a registered nurse). Today, I am here to take your vital signs. It will involve me touching your arm. Are you okay with that?"

Although not legally required, it is best practice to share your pronouns and ask what pronouns the client uses. It is also important to ensure the client's privacy by closing the curtains or the door to the room.

Infection Prevention and Control

Clean hands and clean equipment are essential to infection prevention and control when measuring vital signs. Ensuring cleanliness helps reduce communicable and infectious diseases, particularly healthcare-associated infections, which are infectious organisms acquired by a client while in the hospital. Common infections include *Clostridium difficile* (C. diff), vancomycin-resistant enterococcus (VRE), and methicillin-resistant *Staphylococcus aureus* (MRSA).

Ensuring your hands are clean is the best way to prevent and control infection. *Hand hygiene* can include cleansing with *hand gel* and *hand washing* (see Figure 6.2.1). Use an alcohol-based sanitizer before and after contact with clients. Place gel on your hands and rub all hand surfaces until hands are dry (most guidelines now recommend 20-30 seconds). When washing hands using soap and water, wet your hands and apply soap. Rub all hand surfaces for about 20 to 30 seconds, then rinse your hands. If the tap is not automatic, then turn it off with a paper towel.

Points of Consideration

Hand gel is the preferred method of hand hygiene because it kills more bacteria and is easily accessible to healthcare providers. Soap and water is used when hands/gloves come into contact with bodily fluid



Figure 6.2.1: “Handwashing,” by USDAgov, Flickr, Public Domain.

Equipment

Healthcare providers always inspect equipment before use to ensure it is in good working condition. Equipment (e.g., stethoscopes, pulse oximeters) can be cleaned with alcohol-based solutions to disinfect the surfaces. Automated devices should be regularly serviced to ensure accuracy. Biomedical technicians/experts are responsible for preventative maintenance and calibration to optimize functioning.



Activity: Equipment

Click on the hotspots to learn about the following pieces of equipment:

Quiz Text Description

Photograph of common nursing assessment equipment on a bedside table. The items include a thermometer, oxygen saturation monitor, manual blood pressure cuff, and stethoscope, each used to assess vital signs.

Pain Assessment

A pain assessment is conducted in conjunction with the measurement of vital signs because pain can influence the findings. Pain can activate the sympathetic nervous system and increase pulse, respiration, and blood pressure. Pain is a complex issue, and a comprehensive discussion of pain assessment is beyond the scope of this e-book.

Briefly, because pain is subjective, self-reports are the most effective way to assess pain. The choice of pain assessment tool depends on the client's situation: healthcare providers frequently use a numeric rating scale such as "rate your pain on a scale of 0 to 10, with zero being no pain and ten being the very worst pain that you have ever felt." The response is often recorded on the vital sign record and expanded on in the narrative notes.

OLD CARTSS is a tool for assessing pain. Each letter stands for a series of questions:

- **O** – Onset: When did the symptoms first start, and did they begin suddenly or gradually? What were you doing when it started, and are there any other symptoms accompanying it?
- **L** – Location: Where on the body is the symptom located, or does the pain radiate anywhere else?
- **D** – Duration: How long do the symptoms last, and are they constant or intermittent?
- **C** – Characteristics: What does the symptom feel like? (e.g., sharp, dull, throbbing, aching).
- **A** – Aggravating factors: What makes the symptom worse? (e.g., specific activities, foods, or positions).
- **R** – Relieving factors: What makes the symptom better? (e.g., rest, specific medications, or hot/cold therapy).
- **T** – Treatment: What have you tried so far to address it, and did it work?
- **S** – Severity: How bad is the symptom on a standardized scale (such as 0-10 for pain)?
- **S** – Self-perception: How does this health challenge affect your life?

Note: the framework may be adapted so that L is only used for location. A is used for aggravating and alleviating factors. R is then used for radiation.

Another common tool is the PQRSTU mnemonic, in which each letter corresponds to a series of questions.

- **P** – Provocative/Palliative (e.g., What makes the pain worse? What makes the pain better?)
- **Q** – Quality/Quantity (e.g., Can you describe what the pain feels like? How bad is the pain?)

- **R** – Region/Radiation (e.g., Where is the pain located? Does it radiate anywhere else?)
- **S** – Severity (as noted above, rate the pain on a scale of zero to ten)
- **T** – Timing/Treatment (When did the pain begin? Is it constant? Have you taken anything to help the pain? If so, what?)
- **U** – Understanding (What do you think is causing the pain?)

Order of Vital Sign Measurement

The order of vital sign measurement is influenced by the client's situation. Healthcare providers often place the pulse oximeter probe on a client while proceeding to take pulse, respiration, blood pressure, and temperature. However, in some situations, this order is modified, and the healthcare provider needs to critically assess the situation to prioritize the vital sign measurement order. For example, with newborns/infants, it is best to proceed from least invasive to most invasive, so it is best to begin with respiration, pulse, oxygen saturation, temperature and if required, blood pressure. Generally, it is important to conduct a complete set of vital signs unless otherwise indicated.

Significance of Measurements

Determining the significance of vital sign measurements involves a process of diagnostic reasoning. The healthcare provider analyzes client data and makes decisions about whether the vital signs are normal or abnormal and whether the findings are significant. The following chapters provide normal vital sign ranges. The healthcare provider also considers agency policy, if applicable, about vital sign ranges to assess any abnormal variations and clinical significance. Additionally, the healthcare provider considers the client's baseline vital signs to obtain a better sense of the client's 'normal' and allow comparison (e.g., of trends) over time. The diagnostic reasoning process also involves considering other available objective and subjective data.

Documentation

Timely documentation of vital sign measurements is imperative as a form of communication, to observe trends in vital sign measurements, and to ensure effective intervention when needed. Documentation occurs on paper-based vital sign records or electronic systems depending on the agency. Healthcare providers follow the agency's documentation policy and the professional standards of practice. If using a vital sign record, healthcare providers use the symbols noted on the legend of the record.

After Vital Signs Measurement

After the vital signs measurements have been obtained, the nurse should communicate the findings to the patient. Care should be taken so that the language used is easy for the patient to understand. Most importantly, the nurse should take the opportunity to teach the patient about expected ranges that are conducive to wellness while assessing any factors in the patient's life that may lead to health challenges. The nurse should interpret the vital signs findings holistically in relation to the patient's context, history of illness, medications, and overall treatment plans. For example, if the findings are within expected parameters, but the patient is in distress, the nurse must intervene accordingly. If the findings are unexpected and the patient appears well, the nurse must assess the patient further. Aside from assessing the patient and documenting the care provided, the nurse must also report the situation to the health care team in a timely manner if further medical intervention is needed, and update them on the patient in accordance with professional, ethical, legal, and organizational responsibilities.



Watch: Assessing Vital Signs

Video: “Assessing Vital Signs » Pulse, Respiratory Rate, Blood Pressure, Temperature, Oxygen, Pain” by NurseInTheMaking [8:16] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activity: Test Your Understanding

Quiz Text Description

1. MultiChoice Activity

Which example is an appropriate introduction?

- a. "Hello, my name is Mohammed Jai, and I will be your RN today. I will be taking your blood pressure, which will involve me touching your arm. Are you okay with that?"
- b. "Good morning. My name is Jamal, and I will be your nurse today. I need to take your pulse, which will involve me touching your arm."
- c. "Hi, my name is Sonia Taylor, and I will be your registered nurse today. I will be taking your vital signs (or vitals) before the nurse practitioner arrives for your assessment."
- d. "Hello, my name is Michael, and I will be your RN today. I will be taking your vital signs (or vitals), which will involve me touching your arm. Are you okay with that?"

2. MultiChoice Activity

What is the minimal amount of time a person should wash their hands with soap and water?

- a. 30 seconds
- b. 10 seconds
- c. 20 seconds
- d. 5 seconds
- e. 25 seconds

3. DragText Activity

Drag the correct questions to the PQRSTU word descriptor.

- 1. Provocative ____
- 2. Palliative ____
- 3. Quality ____
- 4. Quantity ____
- 5. Region ____
- 6. Radiation ____
- 7. Severity ____
- 8. Timing ____
- 9. Treatment ____
- 10. Understanding ____

Possible answers:

- Have you taken anything to relieve your pain? If so, what?

- What do you think is causing the pain?
- Can you describe what your pain feels like?
- How bad is your pain?
- Does your pain move around? Do you feel the pain elsewhere?
- When did your pain start? Is it constant?
- How would you rate your pain on a scale of zero to ten, 0 being no pain and 10 being the worst pain you have ever felt?
- Where do you feel your pain? Can you point to where you feel the pain?
- What makes your pain worse?
- What makes your pain feel better?

4. MultiChoice Activity

What vital signs can pain affect? Select all that apply.

- a. Temperature
- b. Pulse
- c. Blood pressure
- d. Respiration
- e. Oxygen saturation

5. DragText Activity

Put the measurements in order from first to last for taking vital signs on a newborn who is not in distress. Drag the words into the correct boxes

1. #1 _____
2. #2 _____
3. #3 _____
4. #4 _____
5. #5 _____

Possible answers:

- Respiration
- Temperature
- Oxygen saturation
- Pulse
- Blood pressure

6. MultiChoice Activity

Which should the nurse always consider when analyzing vital sign measurements? (Select all that apply)

- a. Knowledge of a person's last hospitalization vital sign measurements.
- b. Knowledge of a person's trends in vital sign measurements.
- c. Knowledge of a person's baseline vital signs.
- d. Knowledge of accurate vital sign ranges for the age of the person.

7. DragText Activity

Drag the words into the correct boxes

Documentation can be completed in ____ or ____ format. Make sure to follow ____ policy when recording ____ in the clinical setting.

Possible answers:

- agency
- electronic
- paper
- vital signs

Solution:

1. a. "Hello, my name is Mohammed Jai, and I will be your RN today. I will be taking your blood pressure, which will involve me touching your arm. Are you okay with that?"
2. c. 20 seconds
3. Answer:
 1. Provocative ***What makes your pain worse?***
 2. Palliative ***What makes your pain feel better?***
 3. Quality ***Can you describe what your pain feels like?***
 4. Quantity ***How bad is your pain?***
 5. Region ***Where do you feel your pain? Can you point to where you feel the pain?***
 6. Radiation ***Does your pain move around? Do you feel the pain elsewhere?***
 7. Severity ***How would you rate your pain on a scale of zero to ten, 0 being no pain and 10 being the worst pain you have ever felt?***
 8. Timing ***When did your pain start? Is it constant?***
 9. Treatment ***Have you taken anything to relieve your pain? If so, what?***
 10. Understanding ***What do you think is causing the pain?***
4. b. Pulse; c. Blood pressure; d. Respiration;
5. Answer:
 - #1 ***Respiration***
 - #2 ***Pulse***
 - #3 ***Oxygen saturation***
 - #4 ***Temperature***
 - #5 ***Blood pressure***
6. b. Knowledge of a person's trends in vital sign measurements.; c. Knowledge of a person's baseline vital signs.; d. Knowledge of accurate vital sign ranges for the age of the person.;
7. Documentation can be completed in ***electronic*** or ***paper*** format. Make sure to follow ***agency*** policy when recording ***vital signs*** in the clinical setting.

This section has been adapted from "General Points to Consider in Vital Sign Measurement", in Introduction to Health Assessment for the Nursing Professional (2024) – Canadian edition, by Dr. Jennifer L.

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6.3 Pulses

What is Pulse?

Pulse refers to a pressure wave that expands and recoils the artery when the heart contracts/beats. It is palpated at many points throughout the body. The most common locations for accurately assessing pulse as part of vital sign measurement include *the carotid, radial, brachial, and apical pulses*, as shown in *Figure 6.3.1*. The techniques vary by location, as detailed later.

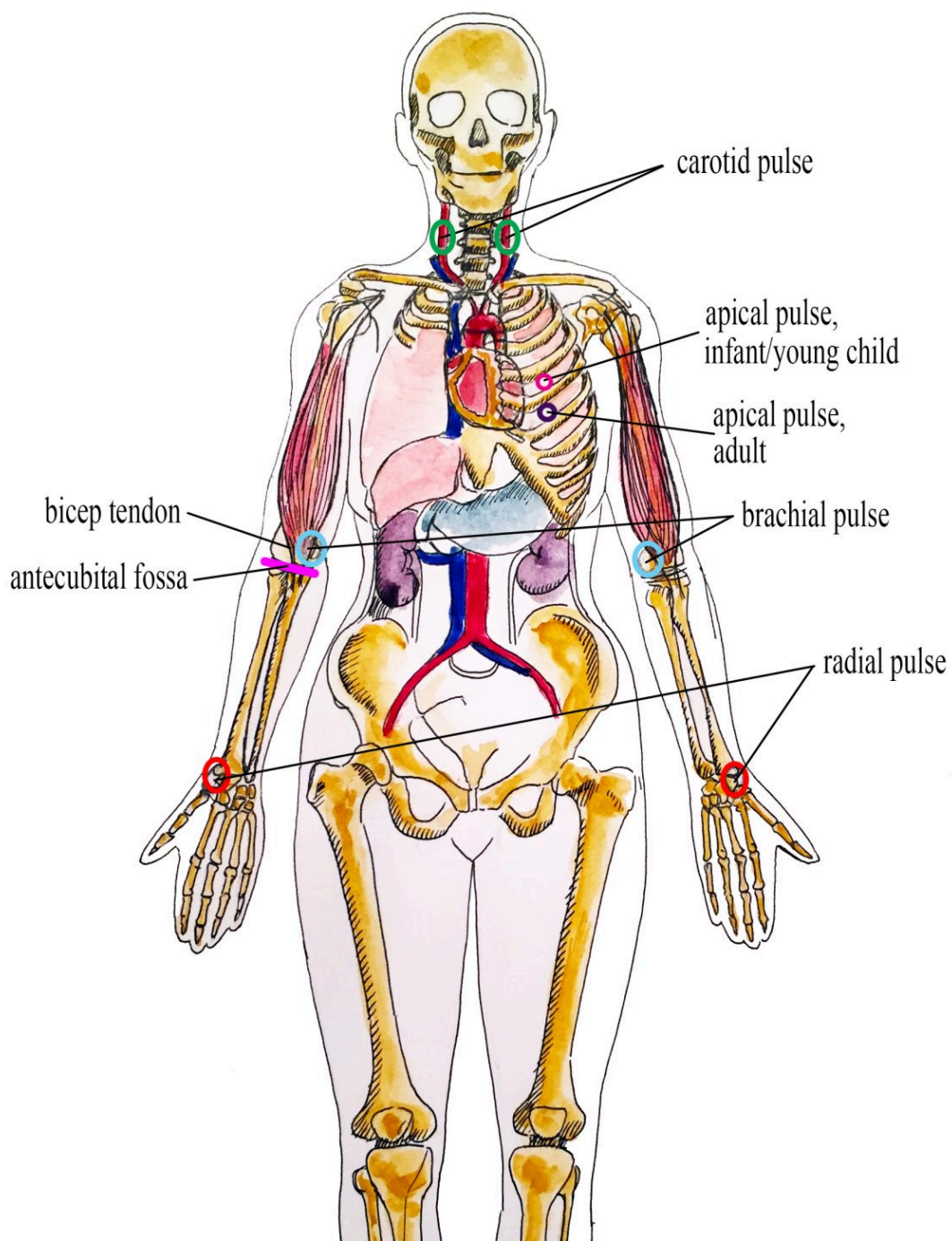


Figure 6.3.1: Radial, brachial, carotid and apical pulse (Illustration credit: Hilary Tang)

Image Description

The image is an anatomical illustration of the upper body showing several common locations used to assess the pulse. The body is shown in frontal view, with bones, major blood vessels, the heart, and arm structures visible.

The diagram labels the following pulse assessment sites and related landmarks:

- **Carotid pulse:** shown on both sides of the neck.
- **Apical pulse, infant/young child:** shown on the chest near the heart.
- **Apical pulse, adult:** shown lower on the chest near the heart.
- **Brachial pulse:** shown near the inner elbow area.
- **Radial pulse:** shown at the wrist on both arms.
- **Bicep tendon:** shown near the front of the elbow.
- **Antecubital fossa:** shown as the inner bend of the elbow.

The image highlights that different pulse sites are assessed at different anatomical locations depending on the patient’s age, condition, and assessment needs.

The heart pumps a volume of blood into the aorta per contraction. This volume is referred to as stroke volume. Age is one factor that influences stroke volume, which ranges from 5–80 mL from newborns to older adults.

Pulse is measured in beats per minute, and the normal adult pulse rate (heart rate) at rest is 60–100 beats per minute. Newborn resting heart rates range from 100–175 bpm. Heart rate gradually decreases until young adulthood and then gradually increases again with age (OER #2). A pregnant woman’s heart rate is slightly higher than her pre-pregnant value (about 15 beats). See Table 6.3.1 for normal heart rate ranges based on age.

Heart Rate Ranges

Table 6.3.1: Heart Rate Ranges

Age	Heart rate (beats per minute)
Newborn to one month	100–170
One month to two years	90–160
Age 2–6 years	70–150
Age 7–11 years	60–130
Age 12–17 years	50–110
Adult and older adult	60–100

Points of Consideration

The ranges noted in Table 6.3.1 are generous. It is important to consider each client and situation to determine whether the heart rate is normal. For example, heart rate is considered in the context of a client's baseline heart rate. The healthcare provider also considers the client's health and illness state and determinants such as rest/sleep, awake/active, and presence of pain. You can expect higher pulse values when a client is in a stressed state, such as when crying or in pain; this is particularly important in the newborn. It is best to complete the assessment when the client is in a resting state. If you obtain a pulse when the client is not in a resting state, document the circumstances (e.g. stress, crying, or pain) and reassess as needed.

Why is Pulse Measured?

Healthcare providers measure pulse because it provides information about a client's state of health and influences diagnostic reasoning and clinical decision-making.

Tachycardia

Tachycardia refers to an elevated heart rate, typically above 100 bpm for an adult. Developmental considerations are important to consider, such as higher resting pulse rates in infants and children. For adults, tachycardia is not normal in a resting state but may be detected in pregnant women or individuals experiencing extreme stress. Tachycardia can be benign, such as when the sympathetic nervous system is activated with exercise and stress. Caffeine intake and nicotine can also elevate the heart rate. Tachycardia is also correlated with fever, anemia, hypoxia, hyperthyroidism, hypersecretion of catecholamines, some cardiomyopathies, some disorders of the valves, and acute exposure to radiation.

Bradycardia

Bradycardia is a condition in which the resting heart rate drops below 60 bpm in adults. In newborns, a resting heart rate below 100 bpm is considered bradycardia. However, a sleeping neonate's pulse may be as low as 90 bpm. People who are physically fit (e.g., trained athletes) typically have lower heart rates. If the client is not exhibiting other symptoms, such as weakness, fatigue, dizziness, fainting, chest discomfort, palpitations, or respiratory distress, bradycardia is generally not considered clinically significant. However, if any of these symptoms are present, this may indicate that the heart is not providing sufficient oxygenated blood to the tissues. Bradycardia can be related to an electrical issue of the heart, ischemia, metabolic disorders, pathologies of the endocrine system, electrolyte imbalances, neurological disorders, prescription medications, and prolonged bed rest, among other conditions. Bradycardia is also related to some medications, such as beta blockers and digoxin.

Points of Consideration

It is vital that healthcare providers assess clients with tachycardia or bradycardia to determine whether the findings are significant and require intervention.



Activity: Test Your Understanding

Quiz Text Description

1. Blanks Activity

The four pulse points that could be checked as part of a normal vital signs measurement are (from the top of the head, down) the ____, ____, ____ and ____.

2. DragText Activity

Drag the words into the correct boxes

1. NB – 1 month = ____
2. 1 month – 2 yr = ____
3. 2 yr – 6 yr = ____
4. 7 yr – 11 yr = ____
5. 12 yr – 18 yr = ____
6. >18 yr = ____

Possible answers:

- 90-160
- 70-150
- 100-175
- 50-110
- 60-100
- 60-130

Solution:

1. The four pulse points that could be checked as part of a normal vital signs measurement are (from the top of the head, down) the **carotid**, **apical**, **brachial** and **radial**.
2. Answer
 1. NB – 1 month = **100-175**
 2. 1 month – 2 yr = **90-160**
 3. 2 yr – 6 yr = **70-150**
 4. 7 yr – 11 yr = **60-130**
 5. 12 yr – 18 yr = **50-110**
 6. >18 yr = **60-100**

Pulse Qualities

The pulse rhythm, rate, force, and equality are assessed when palpating pulses.

Pulse Rhythm

The normal *pulse rhythm* is regular, meaning that the frequency of the pulsation felt by your fingers follows an even tempo with equal intervals between pulsations. If you compare this to music, it involves a constant beat that does not speed up or slow down, but stays at the same tempo. Thus, the interval between pulsations is the same. However, sinus arrhythmia is a common condition in children, adolescents, and young adults. Sinus arrhythmia involves an irregular pulse rhythm in which the pulse rate varies with the respiratory cycle: the heart rate increases at inspiration and decreases back to normal upon expiration. The underlying physiology of sinus arrhythmia is that the heart rate increases to compensate for the decreased stroke volume from the heart's left side upon inspiration.

Points of Consideration

If a pulse has an irregular rhythm, it is important to determine whether it is regularly irregular (e.g., three regular beats and one missed, and this is repeated) or if it is irregularly irregular (e.g., there is no rhythm to the irregularity). Irregularly irregular pulse rhythm is highly specific to atrial fibrillation and is more concerning. Atrial fibrillation is an arrhythmia whereby the atria quiver. This condition can have many consequences, including decreased stroke volume and cardiac output, blood clots, stroke, and heart failure.

Pulse Rate

You count the *pulse rate* for thirty seconds if the rhythm is regular (even tempo) and multiply by two to report in beats per minute. Count for one minute if the rhythm is irregular. In children, pulse is counted for one minute, considering that irregularities in rhythm are common. When the clock is at zero, you say zero, and then the first beat felt by your fingers is counted as one.

Pulse Force

The *pulse force* is the strength of the pulsation felt when palpating the pulse. For example, when you feel a client's pulse against your fingers, is it gentle? Can you barely feel it? Alternatively, is the pulsation very forceful and bounding into your fingertips? The force is important to assess because it reflects the volume of blood, the heart's functioning, cardiac output, and the arteries' elastic properties. Remember, stroke volume refers to the volume of blood pumped with each contraction of the heart (i.e., each heartbeat). Thus, pulse force provides an idea of how hard the heart has to work to pump blood out of the heart and through the circulatory system.

Pulse force is recorded using a four-point scale:

- 3+ Full, bounding

- 2+ Normal/strong
- 1+ Weak, diminished, thready
- 0 Absent/non-palpable

Practice on many people to become skilled in measuring pulse force. While learning, it is helpful to assess pulse force along with an expert because there is a subjective element to the scale. A 1+ force (weak and thready) may reflect a decreased stroke volume and can be associated with conditions such as heart failure, heat exhaustion, or hemorrhagic shock, among other conditions. A 3+ force (full and bounding) may reflect an increased stroke volume and can be associated with exercise and stress, as well as abnormal health states, including fluid overload and high blood pressure.

Pulse Equality

Pulse equality refers to whether the pulse force is comparable on both sides of the body. For example, palpate the radial pulse on the right and left wrist at the same time and compare whether the pulse force is equal. Pulse equality is assessed because it provides data about conditions such as arterial obstructions and aortic coarctation. However, *the carotid pulses should never be palpated at the same time*, as this can decrease and/or compromise cerebral blood flow.

These are the upper body pulse points that will be covered in the following sections.



Activity: Test Your Understanding

Image Description

The H5P hotspot activity shows a front-facing image of an adult upper body from the neck to the wrist. The activity identifies four common upper-body pulse assessment sites.

- **Carotid pulse:** located in the neck, medial to the sternomastoid muscle, between the muscle and the trachea at the level of the cricoid cartilage.
- **Apical pulse:** located on the chest near the heart. In adults, it is found at the fifth intercostal space at the left midclavicular line. In infants and young children, it is found at the fourth intercostal space at the left midclavicular line.
- **Brachial pulse:** located near the inner elbow. It is found by feeling for the bicep tendon in the antecubital fossa area, about 2 cm medial to the tendon and about 2–3 cm above the antecubital fossa.
- **Radial pulse:** located at the wrist, between the radius bone on the thumb side of the wrist and the tendon.

The activity helps learners identify where to assess upper-body pulses during a physical assessment.



Watch: Locating Peripheral Pulses

Video: "LOCATING PERIPHERAL PULSES | ASSESSMENT OF PULSES" by That nursing prof [4:43] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

6.3.1 Carotid

May be taken when the radial pulse is not present or is difficult to palpate.

Technique

Ask the client to sit upright. Locate the carotid artery medial to the sternomastoid muscle (between the muscle and the trachea at the level of the cricoid cartilage, which is in the middle third of the neck). With the pads of your three fingers, gently palpate the carotid artery, one at a time. See *Figure 6.3.2* for the correct placement of fingers.



Figure 6.3.2: Correct placement of fingers

What Should the Healthcare Provider Consider?

Although other pulses can be taken simultaneously to assess equality, the carotid pulses are NEVER taken at the same time. Gently palpate one artery at a time so that you do not stimulate the vagus nerve and compromise arterial blood flow to the brain. Avoid palpating the upper third of the neck, because this is where the carotid sinus area is located. You want to avoid pressure on the carotid sinus area because this can lead to vagal stimulation, which can slow the heart rate, particularly in older adults.

Carotid Technique Tip

Never palpate the carotid pulses simultaneously, as this will reduce and/or compromise cerebral blood flow.

6.3.2 Radial

Technique

Use the pads of your first three fingers to gently palpate the radial pulse (OER #1). The pads of the fingers are placed along the radius bone, which is on the lateral side of the wrist (the thumb side; the bone on the other side of the wrist is the ulnar bone). Place your fingers on the radius bone close to the flexor aspect of the wrist, where the wrist meets the hand and bends. See Figure 6.3.3 for the correct placement of fingers. Press down with your fingers until you can best feel the pulsation. Note the rate, rhythm, force, and equality when measuring the radial pulse (OER #1).



Figure 6.3.3: Correct placement of fingers

What Should the Healthcare Provider Consider?

You may need to adjust the pressure of your fingers when palpating the radial pulse if you cannot feel the pulse. For example, sometimes pressing too hard can obliterate the pulse (make it disappear). Alternatively, if you do not press hard enough, you may not feel a pulse. You may also need to move your fingers around slightly. Radial pulses are difficult to palpate in newborns and children under 5, so healthcare providers usually assess the apical or brachial pulse in these patients.

Radial Technique Tip

When timing the pulse rate, acknowledge/note when your watch is at zero, and then the first beat felt against your fingers is “1” and then continue to count.



Activity: Test Your Understanding

While watching the interactive video on pulse and respiration measurement, apply your knowledge and critical thinking skills to answer the questions throughout the video.

Video: “Radial Pulse / Respiration – Taken Correctly” by Toronto Metropolitan University [2:01] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Points of Consideration

You can use a Doppler ultrasound device if you are struggling to feel the pulse and are concerned about perfusion into the limbs. This is a handheld device that allows you to hear the



whooshing sound of the pulse. The Doppler device is also used following surgery or insertion of a central line to assess blood flow. These devices are most commonly used when assessing peripheral pulses in the lower limbs, such as the dorsalis pedis pulse or the posterior tibial pulse. See *Film clip 6.3.1* for the use of a Doppler device. The Doppler device is also used to locate the brachial pulse and assess blood pressure in infants.

Film clip 6.3.1: “Doppler Device – How to” by Toronto Metropolitan University [1:32] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

6.3.3 Brachial

Brachial pulse rate is measured during some assessments, such as in children, in whom the radial pulse can be difficult to feel. A Doppler can be used to locate the brachial pulse if needed.

Technique

The brachial pulse can be located by feeling the bicep tendon in the area of the antecubital fossa. Move the pads of your three fingers medial (about 2 cm) from the tendon and about 2–3 cm above the antecubital fossa to locate the pulse. See Figure 6.3.4 for the correct placement of fingers along the brachial artery.



Figure 6.3.4: *Correct placement of fingers*

What Should the Healthcare Provider Consider?

It can be helpful to hyper-extend the arm in order to accentuate the brachial pulse so that you can better feel it. You may need to move your fingers around slightly to locate the best place to most accurately feel the pulse. You will usually need to press fairly firmly to palpate the brachial pulse.

6.3.4 Apical

Apical pulse is auscultated with a stethoscope over the chest, where the heart's mitral valve is best heard. In infants and young children, the apical pulse is located at the fourth intercostal space at the left midclavicular line. In adults, the apical pulse is located at the fifth intercostal space at the left midclavicular line. See *Figure 6.3.5* below.

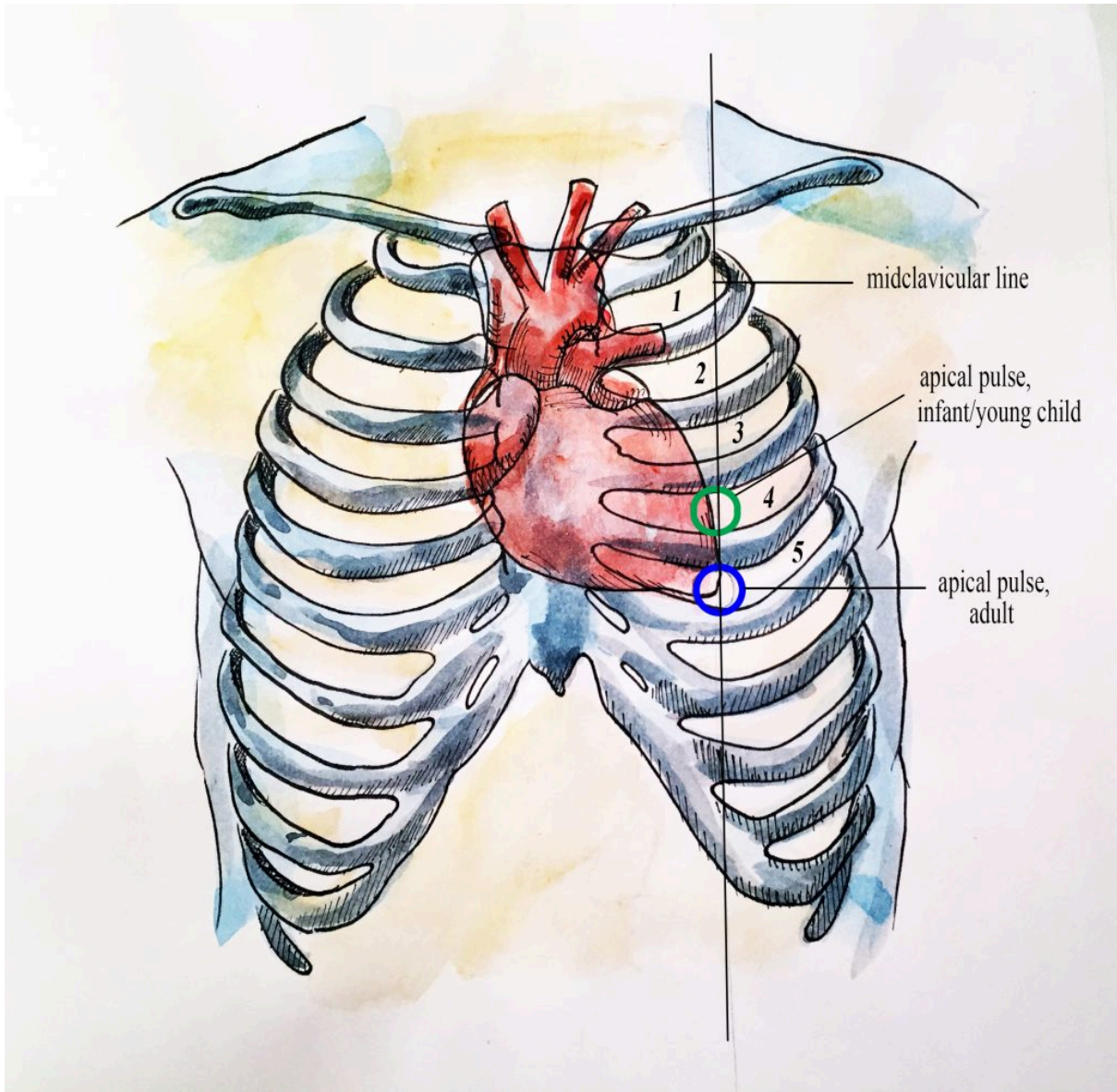


Figure 6.3.5: Apical Pulse (Illustration credit: Hilary Tang)

Image Description

The image is an anatomical illustration of the chest showing the rib cage, heart, and midclavicular line. The ribs are numbered from 1 to 5 on the right side of the image to help identify the approximate intercostal spaces.

The diagram labels two apical pulse locations:

- **Apical pulse, infant/young child:** shown higher on the chest, near the fourth intercostal space.
- **Apical pulse, adult:** shown slightly lower on the chest, near the fifth intercostal space.

The midclavicular line is shown as a vertical reference line used to help locate the correct position for assessing the apical pulse. The image highlights that apical pulse placement differs slightly depending on the patient's age and development.

Apical pulse rate is measured during certain assessments, such as cardiovascular assessments and when a client is taking certain cardiac medications (e.g., digoxin). Sometimes the apical pulse is auscultated pre- and post-medication administration. It is also a best practice to assess apical pulse in infants and children up to five years of age because radial pulses are difficult to palpate and count in this population. It is typical to assess apical pulses in children younger than eighteen, particularly in hospital environments. Apical pulses may also be taken in obese people, because their peripheral pulses are sometimes difficult to palpate.

Technique

Position the client in a supine (lying flat) or in a seated position. Physically palpate the intercostal spaces to locate the landmark of the apical pulse. Ask the female client to reposition her own breast tissue to auscultate the apical pulse. For example, the client gently shifts the breast laterally so that the apical pulse landmark is exposed. Alternatively, the healthcare provider can use the ulnar side of the hand to reposition the breast tissue and auscultate the apical pulse. Ensure draping to protect the client's privacy.

Either the bell or the diaphragm is used to auscultate the client's heart rate and rhythm. There is a pediatric-size stethoscope for infants. Typically, apical pulse rate is taken for a full minute to ensure accuracy; this is particularly important in infants and children due to the possible presence of sinus arrhythmia. In adults, if you are assessing the apical pulse due to an irregular rhythm, then count for one minute. Upon auscultating the apical pulse, you will hear the sounds "lub dup" – this counts as one beat. Continue counting the apical pulse and note the rate and rhythm.

What Should the Healthcare Provider Consider?

Although pulses are best measured at rest, sometimes this is not possible. It is important to document other factors, such as when a person is in pain or an infant/child is crying.

Apical Technique Tip

Feel the intercostal spaces to accurately locate the apical pulse and obtain a physical landmark. There is a space below the clavicle, but the first intercostal space is located below the first rib. You can also slide your fingers down the manubrium where it meets the sternum: this is called the sternal angle (angle of Louis). The second rib extends out from the sternal angle.



Activity: Counting Apical Pulse Rate

Listen to the following audio clip and count the apical pulse. For practice, we have made this clip 30 seconds long, so you will need to multiply it by two to report it as beats per minute (but remember, the most accurate measurement is to count the apical pulse for one minute).

Listen to the audio clip below and count the pulse rate.

Text Description

The number of beats per minute demonstrated in this audio clip are ____ bpm with a ____ rhythm.

Solution:

The number of beats per minute demonstrated in this audio clip are **60** bpm with a **regular** rhythm.

6.3.5 Femoral

The femoral pulse is found in the groin area, where the femoral artery passes beneath the inguinal ligament. It is critical for assessing blood flow to the lower limbs and is especially important during trauma, shock, or suspected arterial occlusion. Because it is a central pulse, its presence indicates adequate cardiac output and major artery patency.

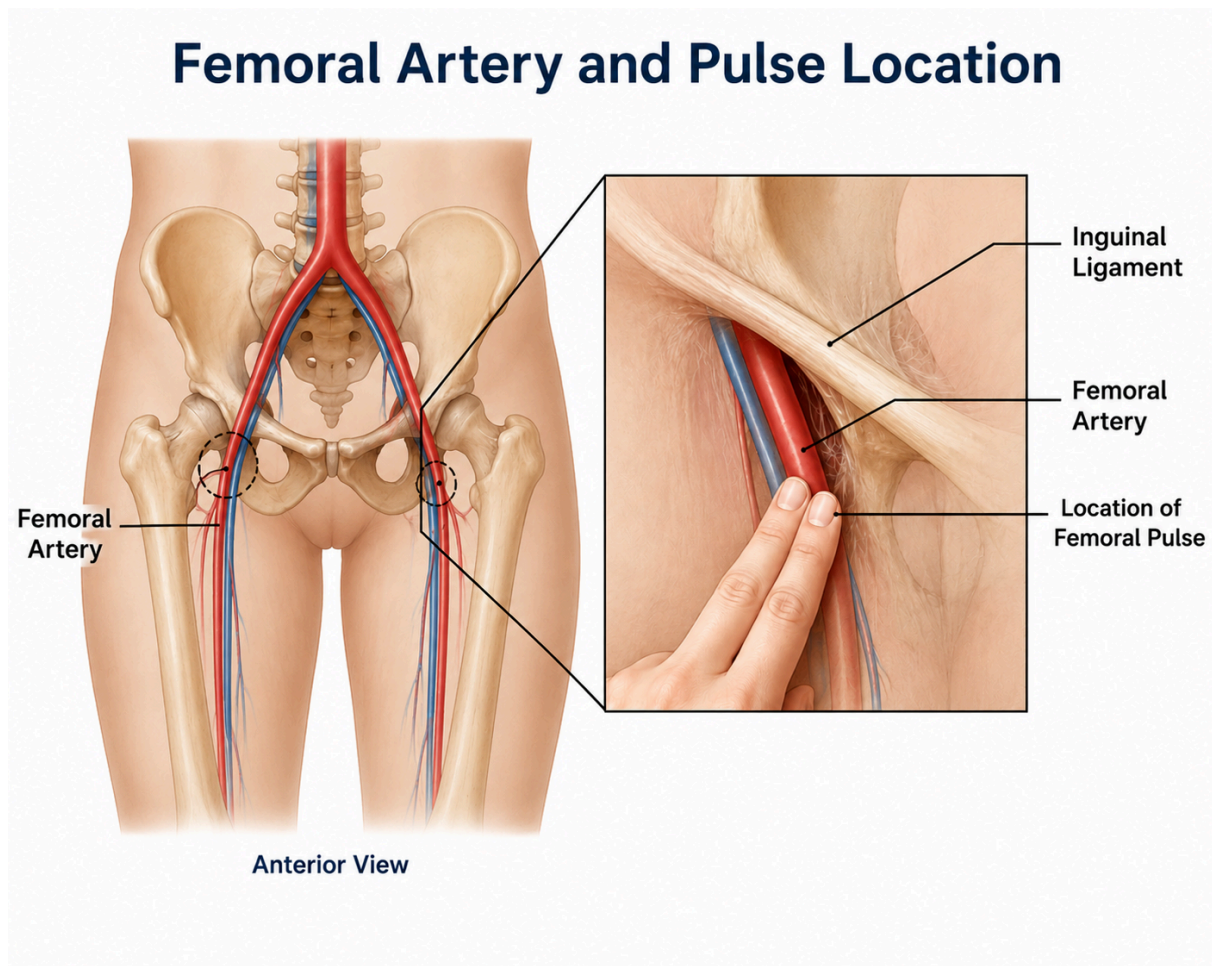


Figure 6.3.6: Femoral pulse. Image: (OpenAI, 2026).

Image Description

This illustration shows the location of the femoral artery and femoral pulse. The left side presents an anterior view of the pelvis and upper thighs, with the femoral arteries highlighted as they travel from the pelvis into the upper legs. The right side provides a close-up view of the groin area, showing the femoral artery passing beneath the inguinal ligament. Two fingers are placed over the artery to indicate where the femoral pulse can be palpated. Labels identify the inguinal ligament, femoral artery, location of the femoral pulse, and anterior view.

6.3.6 Popliteal

Palpated behind the knee within the popliteal fossa, the popliteal pulse is deeper and can be more challenging to locate. It is assessed to evaluate circulation to the lower leg and foot, particularly when peripheral pulses are diminished. This pulse site is valuable in diagnosing peripheral vascular disease or arterial blockages in the lower extremities.

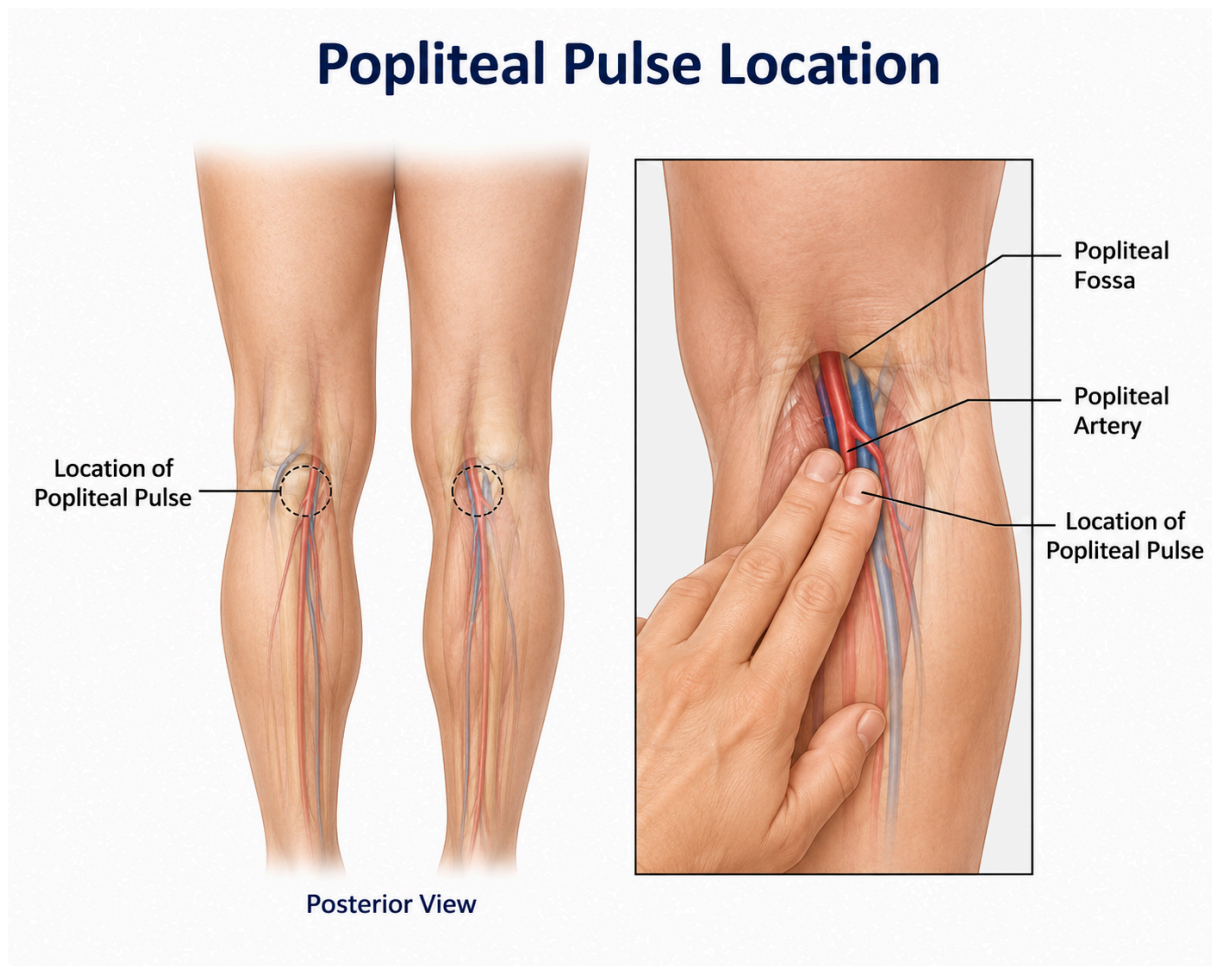


Figure 6.3.7: Popliteal pulse. Image: (OpenAI, 2026).

Image Description

This illustration shows the location of the popliteal pulse. The left side presents a posterior view of both legs, with the pulse location marked behind each knee. The right side provides a close-up view of the back of the knee, showing the popliteal artery within the popliteal fossa. Fingers are placed over the artery to demonstrate where the popliteal pulse can be palpated. Labels identify the popliteal fossa, popliteal artery, location of the popliteal pulse, and posterior view.

6.3.7 Posterior Tibial

Palpated behind the knee within the popliteal fossa, the popliteal pulse is deeper and can be more challenging to locate. It is assessed to evaluate circulation to the lower leg and foot, particularly when peripheral pulses are diminished. This pulse site is valuable in diagnosing peripheral vascular disease or arterial blockages in the lower extremities.

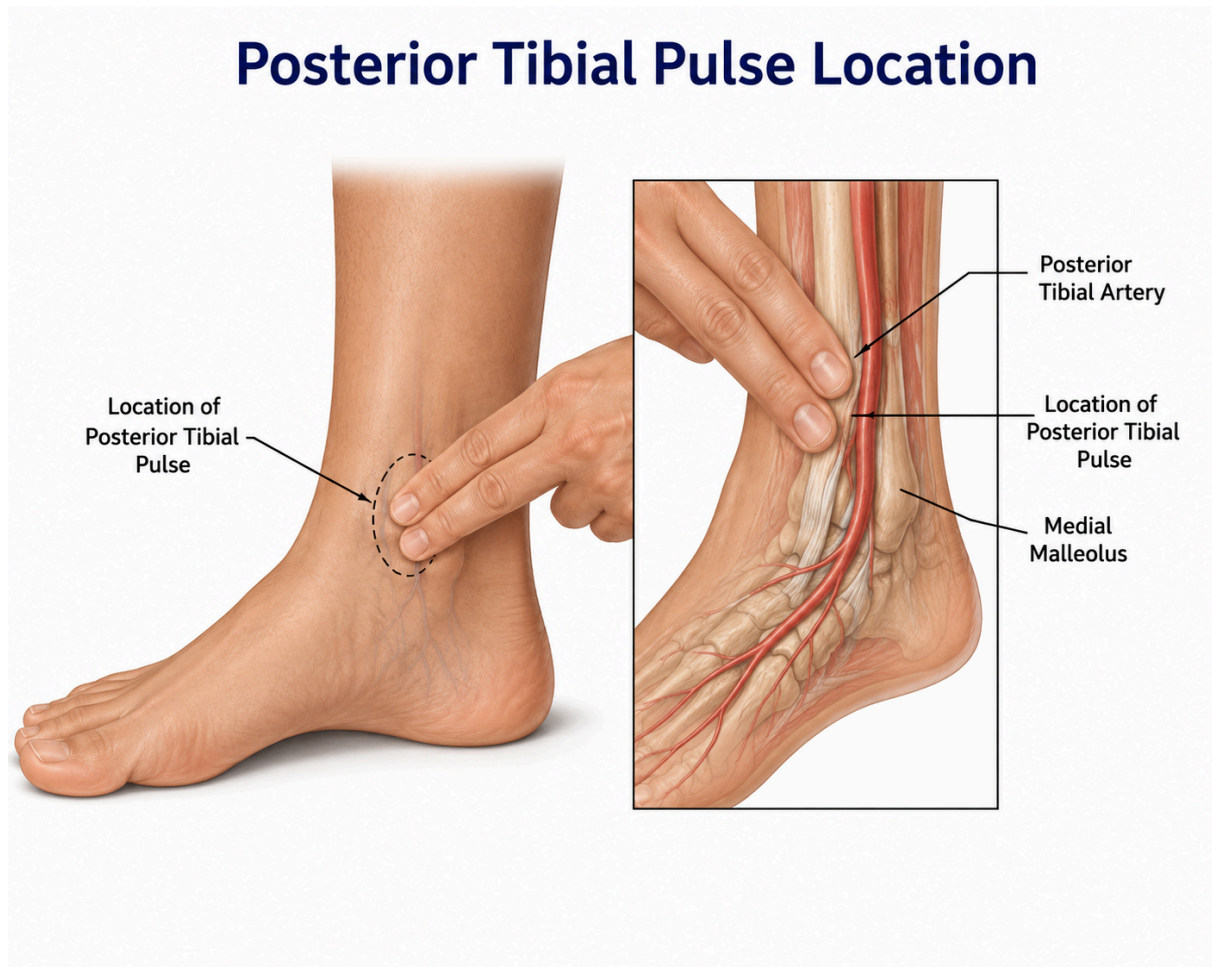


Figure 6.3.8: Posterior tibial pulse. Image: (OpenAI, 2026).

Image Description

This illustration shows the location of the posterior tibial pulse. The main image shows the inner side of the ankle, with fingers placed just behind the medial malleolus to demonstrate where the pulse can be palpated. The inset provides a closer anatomical view of the posterior tibial artery as it travels behind the medial malleolus. Labels identify the posterior tibial artery, medial malleolus, and location of the posterior tibial pulse.

6.3.8 Dorsalis Pedis

Found on the dorsal (top) surface of the foot, lateral to the extensor tendon of the big toe, the dorsalis pedis pulse helps evaluate peripheral circulation. It is routinely checked in patients at risk for peripheral artery disease, diabetes, or other conditions that impair blood flow to the lower extremities. Its presence confirms adequate arterial supply to the foot.

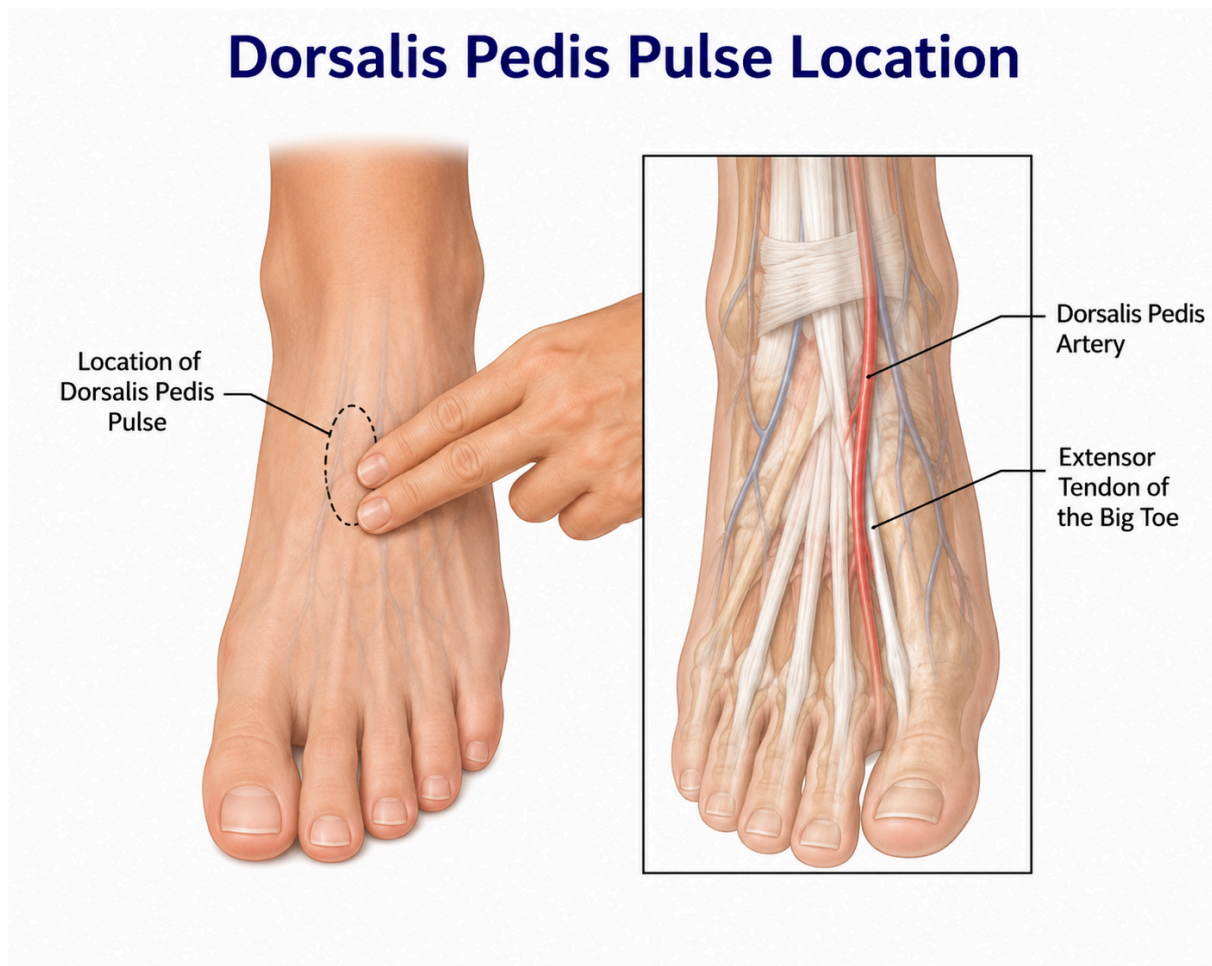


Figure 6.3.9: Dorsalis pedis pulse. Image: (OpenAI, 2026).

Image Description

This illustration shows the location of the dorsalis pedis pulse. The main image shows the top surface of the foot, with fingers placed over the pulse site. The inset provides a closer anatomical view of the dorsalis pedis artery and the extensor tendon of the big toe. Labels identify the dorsalis pedis artery, the extensor tendon of the big toe, and the location of the dorsalis pedis pulse.



Watch: 9 Pulse Points Assessment on the Body

Video: “Radial Pulse / Respiration – Taken Correctly” by Toronto Metropolitan University [2:01] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activities: Test Your Understanding

Activity 1

Image Description

The H5P hotspot activity shows a front-facing image of an adult upper body from the neck to the wrist. Learners are asked to find all the pulse points shown in the image.

The activity includes four pulse assessment locations:

- **Carotid pulse:** located at the side of the neck.
- **Apical pulse:** located on the left side of the chest near the heart.
- **Brachial pulse:** located near the inner elbow area.
- **Radial pulse:** located at the wrist on the thumb side of the forearm.

The activity helps learners practise identifying common upper-body pulse sites used during a nursing assessment.

Activity 2

Quiz Text Description

1. MultiChoice Activity

Pulse refers to:

- The volume of blood that moves through the artery when the heart contracts/beats
- The volume of blood that moves through the vein when the heart contracts/beats
- The pressure wave that expands and recoils the vein when the heart contracts/beats
- The pressure wave that expands and recoils the artery when the heart contracts/beats

2. MultiChoice Activity

Which of the following are true about stroke volume? (Choose all that apply)

- It refers to the volume of blood pumped into the aorta per contraction
- It ranges from 5–80 mL from newborns to older adults
- Age is one factor that influences stroke volume
- It is measured in beats per minute

3. Blanks Activity

Tachycardia refers to an elevated heart rate, typically above ____ bpm in an adult.

4. Blanks Activity

Bradycardia is a condition in which the resting heart rate drops below ____ bpm in an adult.

5. DragText Activity

Drag the words into the correct boxes

1. Match the appropriate number with the pulse force description:
- 2.
3. ____ = 3+
4. ____ = 2+
5. ____ = 1+
6. ____ = 0

Possible answers:

- Full, bounding
- Absent/non-palpable
- Weak, diminished
- Normal/strong

6. TrueFalse Activity

Bradycardia is always considered clinically significant (True/False)

7. TrueFalse Activity

Tachycardia is always considered clinically significant. (True/False)

Solution:

1. d. The pressure wave that expands and recoils the artery when the heart contracts/beats
2. a. It refers to the volume of blood pumped into the aorta per contraction; b. It ranges from 5–80 mL from newborns to older adults; c. Age is one factor that influences stroke volume; d. It is measured in beats per minute;
3. Tachycardia refers to an elevated heart rate, typically above **100** bpm in an adult.
4. Bradycardia is a condition in which the resting heart rate drops below **60** bpm in an adult.
5. Answer
 1. **Full, bounding** = 3+
 2. **Normal/strong** = 2+
 3. **Weak, diminished** = 1+
 4. **Absent/non-palpable** = 0
6. False
7. False

This section has been adapted from “Chapter 7: Vital Signs” in Introduction to Health Assessment for the Nursing Professional (2024) – Canadian edition Copyright © by Lapum and Hughes is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted.

Note: Pulse-location illustrations for Figures 6.3.6 to 6.3.9 were generated using ChatGPT (OpenAI) and subsequently reviewed and edited by the authors for educational use.

OpenAI. (2026). *ChatGPT* (GPT-5.5 Thinking) [Large language model]. <https://chatgpt.com/>

Prompt

Create a labelled medical illustration showing the location of the “X” pulse based on the provided chapter description.”

6.4 Respirations

Respiration Defined

Respiration refers to a person's breathing and the movement of air into and out of the lungs.

The respiratory system provides oxygen to body tissues for cellular respiration, removes the waste product carbon dioxide, and helps maintain acid–base balance. Inspiration is the process that causes air to enter the lungs, and expiration is the process that causes air to leave the lungs. A respiratory cycle (or one breath while you are measuring respiratory rate) is one sequence of inspiration and expiration. Respiration is assessed for *quality*, *rhythm*, and *rate*.

The *quality* of a person's breathing is normally relaxed and silent. Healthcare providers assess the use of accessory muscles in the neck and chest and the indrawing of intercostal spaces (also referred to as intercostal tugging), which can indicate respiratory distress. Respiratory distress can also cause nasal flaring, and the person often moves into a tripod position. The tripod position involves leaning forward and placing arms/hands and/or upper body on one's knees or on the bedside table.

Respiration normally has a regular *rhythm*. A regular rhythm means that the frequency of the respiration follows an even tempo with equal intervals between each respiration. If you compare this to music, it involves a constant beat that does not speed up or slow down, but stays at the same tempo.

Respiratory *rates* vary based on age. The normal resting respiratory rate for adults is 10–20 breaths per minute. Children younger than one year typically have a respiratory rate of 30–60 breaths per minute, but by age ten, the normal rate is usually 18–30 breaths per minute. By adolescence, the respiratory rate is usually similar to that of adults, 12–18 breaths per minute. The normal respiratory rate for children decreases from birth to adolescence. Respiratory rates often increase slightly over the age of sixty-five.

Estimated respiratory *rates* vary based on the source. Table 6.4.1 lists a generous range of normal respiratory rates based on age. It is important to consider the client and the situation to determine whether the respiratory rate is normal. Always check with the institution where you work about their normal respiratory rate ranges. Healthcare providers take into consideration the client's health and illness state and determinants such as rest/sleep, awake/active, presence of pain, and crying when assessing the respiratory rate.

Table 6.4.1: Respiratory Rate Ranges

Age	Rate (breaths per minute)
Newborn to 1 year	30–60
One to six years	22–40
7–11 years	18–30
12–17 years	12–22
Adults and older adults	10–20



Watch: On Respiration

Video: “Counting Respirations Nursing Skill Assessment | Respiratory Rate CNA Skill” by RegisteredNurseRN [5:33] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Video: “How to Count a Respiratory Rate – EMTprep.com” by EMTprep [0:32] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

6.4.1 Assessment of Pulse and Respirations

Technique

The respiratory rate is counted after taking the pulse rate so that the client is not aware that you are taking it. Once you have finished counting the pulse, leave your fingers in place and then begin assessing respiration. Best to assess with the client in an upright position (sitting or high Fowlers) so that the lungs can fully inflate. Observe the chest or abdomen rise and fall. One respiration includes a full respiratory cycle (including both inspiration and expiration). Thus, the rise and the fall of the abdomen or chest is counted as one full breath. Count for 30 seconds if the rhythm is regular or for a full minute if irregular. Report the respiration as breaths per minute, as well as whether breathing is relaxed, silent, and has a regular rhythm. Report whether chest movement is symmetrical.

What Should the Healthcare Provider Consider?

Assess the movement of the chest with adults, and the movement of the abdomen with newborns and infants. Adults are normally thoracic breathers (the chest moves) while infants are normally diaphragmatic breathers (the abdomen moves). Some adults are abdominal breathers. Breathing rates are counted for one minute with infants because the respiratory rhythm (tempo) can vary significantly. For example, the breathing rates of infants can speed up and slow down with some short periods of apnea (pauses in breathing).

When assessing respiration, ensure that thick and bulky clothing is removed so you can clearly see the rise and fall of the chest or abdomen. Although respiratory rates are best counted at rest, sometimes this is not possible (e.g., in an emergency situation and with a child who is crying). In this case, document the situation. While assessing respirations, it is important to note signs of respiratory distress, which can include loud breathing, nasal flaring, and intercostal retractions. See *Figure 6.4.1* for signs of respiratory distress. These signs require further assessment and intervention.

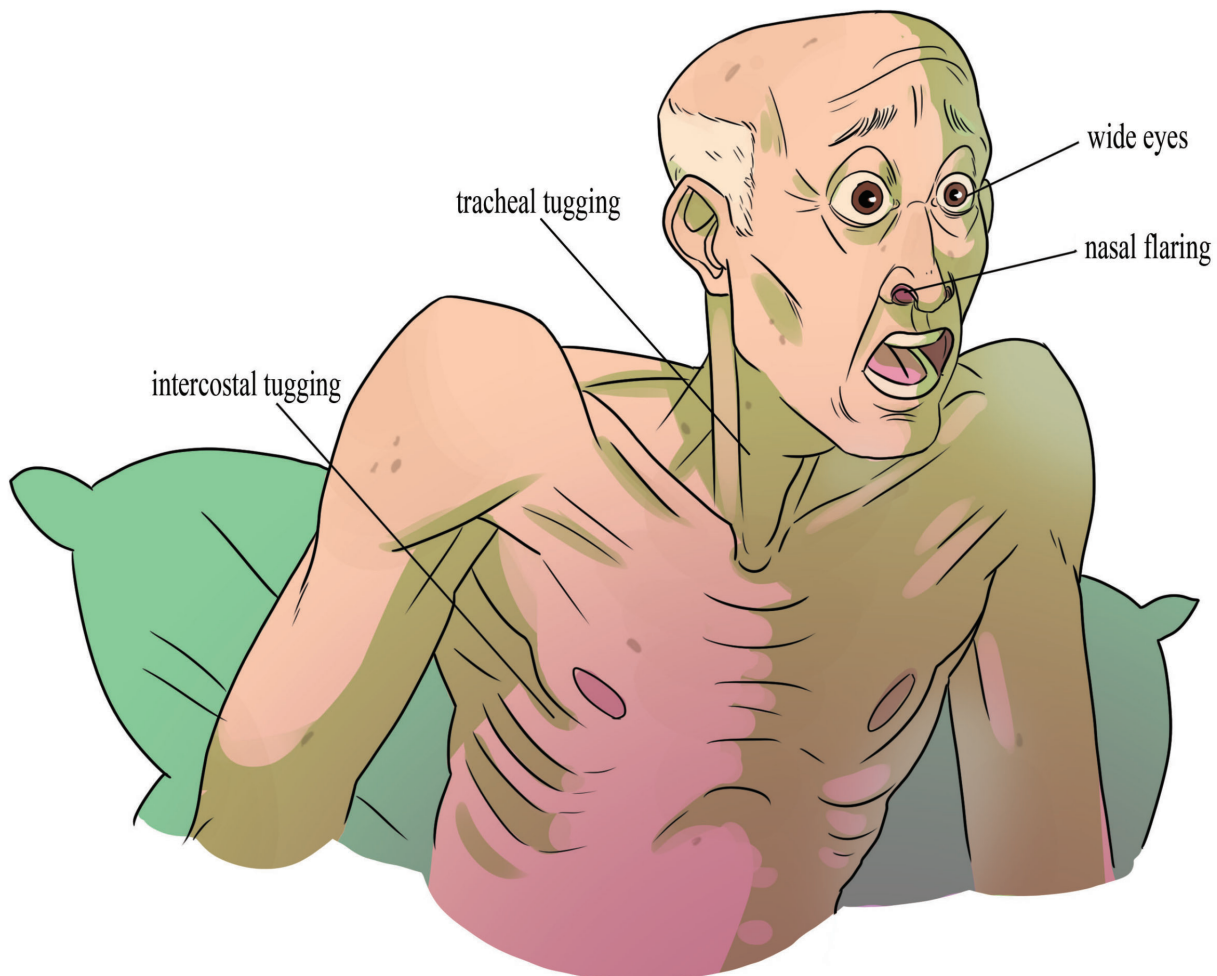


Figure 6.4.1: Signs of respiratory distress (Illustration credit: Paige Jones)

Image Description

The image is an illustration of a person experiencing respiratory distress. The person is sitting upright with an open mouth, wide eyes, and visible effort while breathing.

The diagram labels four signs of respiratory distress:

- **Tracheal tugging:** visible pulling at the lower neck area during breathing.
- **Intercostal tugging:** visible pulling in between the ribs during breathing.
- **Wide eyes:** an expression that may indicate fear, anxiety, or increased breathing effort.
- **Nasal flaring:** widening of the nostrils during breathing.

The image highlights visual cues that may suggest increased work of breathing and the need for further respiratory assessment.



Activities: Test Your Knowledge

Activity 1

Video Description and Transcript

This interactive video is titled **Normal Breathing**. It demonstrates normal breathing as part of a respiration assessment. The activity includes on-screen teaching notes that explain how and when to assess respirations.

Transcript of on-screen text:

- **Opening title:** Normal Breathing
- **Teaching note 1:** It is best to move right from counting a person's pulse to counting their respirations without moving your fingers from the pulse point.
- **Teaching note 2:** If a person knows you are counting their respirations, they are likely to focus on their own breathing, and they may change their breathing pattern.
- **Teaching note 3:** When possible, it is best to count a person's pulse and respirations while they are in a relaxed, resting state.

Summary: The video emphasizes that respirations should be assessed discreetly after counting the pulse, because a person may consciously change their breathing if they know it is being observed. It also reinforces that pulse and respirations should be assessed when the person is relaxed and resting whenever possible.

Activity 2

Text Description

How many breaths per minute did you count (use numbers)? ____ bpm

Solution:

How many breaths per minute did you count (use numbers)? **12** bpm

Activity 3

Quiz Text Description

1. DragText Activity

Drag the words into the correct boxes

1. The characteristics of the respirations _____
2. The process that causes air to enter the lungs _____
3. The frequency of the respiratory cycle _____
4. The process that causes air to leave the lungs _____
5. The tempo of the respirations _____
6. One sequence of inspiration and expiration _____

Possible answers:

- A respiratory cycle
- Quality
- Rhythm
- Rate
- Inspiration
- Expiration

2. MultiChoice Activity

Which of the following are/is true about respirations? (choose all that apply)

- a. One respiration includes a full respiratory cycle (including both inspiration and expiration)
- b. It is best to inform the client that you are counting their respirations
- c. The respiration rate is reported as breaths per minute
- d. Adults are normally abdominal breathers

3. DragText Activity

Drag the ranges into the correct boxes

1. _____ = Newborn to six months.
2. _____ = Six months to one year.
3. _____ = 2 to 6 years.
4. _____ = 7 to 11 years.
5. _____ = 12 to 18 years.
6. _____ = Adult and older adults.

Possible answers:

- 22-36
- 10-20
- 26-40
- 12-20
- 18-30
- 30-60

Solution:

1. Answers
 1. The characteristics of the respirations **Quality**
 2. The process that causes air to enter the lungs **Inspiration**

3. The frequency of the respiratory cycle **Rate**
 4. The process that causes air to leave the lungs **Expiration**
 5. The tempo of the respirations **Rhythm**
 6. One sequence of inspiration and expiration **A respiratory cycle**
2. a. One respiration includes a full respiratory cycle (including both inspiration and expiration); c. The respiration rate is reported as breaths per minute;
 3. Answers
 1. **30-60** = Newborn to six months.
 2. **26-40** = Six months to one year.
 3. **22-36** = 2 to 6 years.
 4. **18-30** = 7 to 11 years.
 5. **12-20** = 12 to 18 years.
 6. **10-20** = Adult and older adults.

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6.5 Oxygen Saturation

What is Oxygen Saturation?

Oxygen saturation refers to the percentage of hemoglobin molecules saturated with oxygen. Hemoglobin molecules can each carry four oxygen molecules; the oxygen binds or attaches to hemoglobin molecules. Oxygen saturation provides information about how much hemoglobin is carrying oxygen, compared to how much hemoglobin is not carrying oxygen.

Why is Oxygen Saturation Measured?

Healthcare providers measure oxygen saturation because it provides information about a client's state of health. The body's tissues and organs require oxygen for metabolism, and oxygen saturation can reveal whether there is sufficient oxygen in the blood or whether the client is in a state called hypoxemia (insufficient oxygen in the blood).

Oxygen saturation levels can influence clinical decisions about whether the client is receiving sufficient oxygen and/or requires supplemental oxygen. Oxygen saturation levels are also monitored during and after surgeries and treatments, and to assess a client's capacity for increased activity.

How is Oxygen Saturation Measured?

Oxygen saturation can be measured using a pulse oximetry device. See Figure 6.5.1 for a pulse oximeter. It is a non-invasive method that gives an instant estimate of arterial oxygen saturation levels. In critically ill clients, a more accurate, but invasive approach is drawing arterial blood or using a continuous monitoring system to measure arterial blood gases through an arterial line. An arterial line is a catheter that is inserted into an artery, usually the radial artery. It provides a way to access blood gases, including arterial oxygen saturation (SaO₂). Here, we focus on pulse oximetry because it is identified as a vital sign.



Example: Pulse Oximeter

Figure 6.5.1: A pulse oximeter

Image Description

The H5P hotspot image shows a pulse oximeter being used to assess oxygen saturation and pulse rate. A probe is clipped to a patient's finger and connected by a cord to a handheld monitor.

The monitor displays two main readings:

- **SpO₂:** The oxygen saturation reading is shown as 98.
- **Pulse:** The pulse reading is shown as 89 beats per minute.

The activity also identifies parts of the device, including the finger probe and the on/off buttons. The image helps learners recognize the components of a pulse oximeter and understand where to locate oxygen saturation and pulse readings on the monitor.

A pulse oximetry device includes a sensor that measures light absorption of hemoglobin and represents arterial SpO₂. Oxyhemoglobin and unoxygenated hemoglobin absorb light differently. The sensor measures “the relative amount of light absorbed by oxyhemoglobin and unoxygenated (reduced) hemoglobin” and compares the amount of “light emitted to light absorbed” (Jarvis, 2014). This comparison is then converted to a ratio and is expressed as a percentage of SpO₂.

Points of Consideration

A pulse oximeter reading reflects arterial oxygen saturation levels, as opposed to venous oxygen saturation levels, because the device only measures light absorption of pulsatile flow: the ‘p’ in SpO₂ refers to pulse or pulsatile flow. If pulsatile flow is limited or obstructed, an oxygen saturation level will not be accurate. For example, the compression of a blood pressure cuff will obliterate the pulsatile flow, so blood pressure and pulse oximetry should not be taken simultaneously on the same limb.

The sensor is attached using various devices. One is a spring-loaded clip attached to a finger or toe, as shown previously in *Figure 6.5.1*. It is used when an intermittent measurement is required. However, this clip is too large for newborns and young children, so for this population, the sensor is taped to a finger or toe. See *Figure 6.5.2*. This technique is also used for clients who require continuous monitoring.



Figure 6.5.2: Pulse oximeter with sensor taped around finger

An earlobe clip is another useful device for clients who cannot tolerate the finger or toe clip or have a condition that could affect the results, such as vasoconstriction and poor peripheral perfusion. Another type of device is taped across the forehead and left in place for continuous monitoring. See *Figure 6.5.3*.



Figure 6.5.3: Pulse oximeter with device across forehead

6.5.1 Oxygen Saturation Levels

Normal oxygen saturation ranges from 97–100% in a healthy individual. However, there are reasons why a lower range occurs and, in some cases, why it is sometimes acceptable.

Older adults typically have lower oxygen saturation levels than younger adults. For example, someone older than 70 years of age may have an oxygen saturation level of about 95%, which is an acceptable level.

It is important to note that the oxygen saturation level *varies* considerably depending on a person's health status. Thus, it is important to understand both *baseline readings* and the *underlying physiology* associated with certain conditions to interpret oxygen saturation levels and changes in these levels.

- People who are obese and/or have conditions such as lung and cardiovascular diseases, emphysema, chronic obstructive pulmonary disease, congenital heart disease and sleep apnea tend to have lower oxygen saturation levels.
- Smoking can influence the accuracy of pulse oximetry, in which the SpO_2 is low or falsely high, depending on whether hypercapnia is present. With hypercapnia, it is difficult for the pulse oximeter to differentiate oxygen in the blood from carbon monoxide (caused by smoking).
- Oxygen saturation levels may decrease slightly when a person is talking.
- Oxygen saturation may remain normal (e.g., 97% and higher) for people with anemia. However, this may not indicate adequate oxygenation because there are less hemoglobin to carry an adequate supply of oxy-

gen for people who have anemia. The inadequate supply of oxygen may be more prominent during activity for people with anemia.

- Falsely low oxygen saturation levels may be associated with hypothermia, decreased peripheral perfusion, and cold extremities. In these cases, an ear lobe pulse oximeter device or arterial blood gases would provide a more accurate oxygen saturation level. However, arterial blood gases are usually only taken in critical care or emergency settings.

Points of Consideration

In practice, such as a hospital setting, the SpO₂ range of 92–100% is generally acceptable for most clients. Some experts have suggested that a SpO₂ level of at least 90% will prevent hypoxic tissue injury and ensure client safety (Beasley et al., 2016). However, with children, a saturation that drops below the normal of 97%–100% is always something that you should investigate further. If a client's oxygen saturation levels are low, you should have them sit upright so their lungs can fully expand and then perform a focused respiratory assessment.



Contextualizing Inclusivity – Pulse Oximetry Biases

There are biases ingrained in the technology of pulse oximetry, which result in racial disparities in care. Despite decades of research showing the inherent and systematic racism that is part of pulse oximetry (Hidalgo et al., 2021), practices have been slow to change. This is a serious issue considering that treatment decisions are influenced by pulse oximetry, and hypoxemia can lead to complications, including higher mortality rates and organ dysfunction (Wong et al., 2021)

In the context of hypoxemia, pulse oximeters have been found to generally overestimate oxygen saturations (Feiner et al., 2007), particularly as the SpO₂ lowers to 88%. This overestimation is sometimes described as hidden hypoxemia (Wong et al., 2021) in which the oxygen saturation on a pulse oximeter is higher than the oxygen saturation measured via arterial blood draw. For several years, this overestimation has been particularly greatest in people with darker skin tones (Bickler et al., 2005; Feiner et al., 2007). For example, it has been noted that hypoxemia is detected (via pulse oximetry) less in Black patients than in white patients (Sjoding et al., 2020). In a large, multi-site study with over 79,000 patients, it was found that hidden hypoxemia was found more in Black patients, followed by Hispanic and then similar rates for Asian and white patients (Wong et al., 2021). In another study in the context of COVID-19, hidden hypoxemia was found more in Asian, Black and Hispanic patients than white patients and significantly affected treatment in Black and Hispanic patients (Fawzy et al., 2022).

As you go into practice, keep in mind that you should critically reflect on your pulse oximetry findings. For example, if the client's SpO₂ finding is normal, but they are presenting with difficulty breathing or signs of respiratory distress (e.g., shortness of breath, audible breathing, tripod position, intercostal tugging/pulling/retractions), consider your priorities of care. First, always believe the patient and then consider the findings in the context of your subjective assessment and other physical findings. It may be appropriate to advocate for arterial blood gases to be drawn to verify oxygen saturation levels if the patient is having breathing problems and their pulse oximetry findings are normal.



Priorities of Care

You want to assess whether a client who has low oxygen saturation levels is in respiratory distress. To determine if a client is in respiratory distress and requires immediate intervention, you should first ask the client if they are having any shortness of breath (difficulty breathing). In addition, you should observe for any altered level of consciousness (confusion, lethargy) and increased work of breathing, such as tachypnea, nasal flaring, audible sounds when breathing (e.g., gasping for air), accessory muscle use (e.g., neck and abdominal muscles), and intercostal retractions (when the skin pulls in between the ribs). If the client shows signs of respiratory distress, stay with the client and call for assistance (a senior nurse, physician, or nurse practitioner).

- If an airway is not patent, try to open the airway with a head-tilt-chin-lift and inspect the mouth and nose for obstructions.
- Supplemental oxygen can be applied if there are **standing orders** on your unit.

You may need to keep the client in a supine position if you suspect that they are deteriorating quickly and may go into respiratory or cardiac arrest. Notify the **critical care response team (CCRT)** or call a code in this case. **Bag-mask ventilation** may be needed if the client is in respiratory arrest.

If you suspect the client is choking, stay with the client and call for help while you place them in a high Fowler's position. If they are able to, encourage them to cough and clear their airway. You may need to suction the oral cavity and airway, if possible. If you suspect a complete obstruction, use a combination of "back blows, abdominal thrusts, and chest thrusts" (Canadian Red Cross).

However, it is important to consider contextual variables. If the client has low oxygen saturation levels but shows no other signs of respiratory distress, take some time to consider why the oxygen saturation levels are low. If oxygen saturations are low, try some less urgent interventions such as waking them up if they are sleeping, having them sit upright so their lungs can fully expand, and asking them to take a few deep breaths.



Activity: Test Your Understanding

Quiz Text Description

1. Blanks Activity

The normal oxygen saturation level is ____% to ____%.

2. MultiChoice Activity

2. Kathleen is a 72-year old female who came to the clinic due to nausea and vomiting for the last 3 days. She has not been sleeping well and stated she's had migraines for the past 5 days. Kathleen's oxygen saturation level is 95%. What is the rationale for Kathleen's lower oxygen saturation level?

- a. Nausea
- b. Migraines
- c. Age
- d. Lack of sleep

3. MultiChoice Activity

3. Which underlying physiological conditions can cause individuals to have lower oxygen saturation levels? Select all that apply.

- a. Sleep apnea
- b. Hyperthyroidism
- c. Emphysema
- d. Migraines
- e. Obesity
- f. Congenital heart disease
- g. Chronic obstructive pulmonary disease
- h. Cirrhosis
- i. Diabetes

4. MultiChoice Activity

4. A client was admitted to the emergency department after falling through the ice while skating on Lake Ontario. The client was submerged in the water for 5 minutes before being rescued. The client's oxygen saturation level is 80%. What should the nurse do next?

- a. Attach an ear lobe pulse oximeter device.
- b. Call for help immediately.
- c. Change the pulse oximeter device to the other hand.
- d. Order arterial blood gases.

Solution:

1. The normal oxygen saturation level is **97%** to **100%**.
2. c. Age
3. a. Sleep apnea; c. Emphysema; e. Obesity; g. Chronic obstructive pulmonary disease;
4. a. Attach an ear lobe pulse oximeter device.

6.5.2 Oxygen Saturation Technique

Technique

The pulse oximeter probe is clipped onto or taped around a client's finger, as shown in Figure 6.5.3. If doing automatic blood pressures, put the oximeter probe on a finger on the opposite arm. The device displays an oxygen saturation level and a pulse within a few seconds. Palpate the client's radial pulse (taken for 30 seconds if regular and one minute if irregular) while the oximeter is attached to the finger. The healthcare provider can have confidence in the accuracy of the measurement of the oxygen saturation level if the pulse displayed on the oximeter coincides with the radial pulse.



Figure 6.5.3: Measuring oxygen saturation

Points of Consideration

Nail polish or artificial nails can interact with the absorption of light waves and influence the accuracy of the SpO₂ measurement when using a probe clipped on the finger. Remove nail polish or use an alternative method. It is best to measure oxygen saturation on the opposite hand if you are performing automatic blood pressure on one of the arms.

What Should the Healthcare Provider Consider?

Many factors can influence accuracy when measuring oxygen saturation levels via pulse oximetry. Certain conditions, including poor circulation and peripheral vasoconstriction, can lead to inaccurate oxygen saturation measurements when the device is attached to a finger or toe.

Vasoconstriction involves the narrowing of the vessels, so blood flow is reduced to the peripheries. This can reduce the accuracy of the reading and reduce the oximeter's capacity to detect a signal. Readings may also be inaccurate (low) if a client's hands or feet are cold or if they have poor circulation. In cases like these, use an alternate method of measurement, like clipping a device to the earlobe or taping it to the forehead.

The healthcare provider cannot have confidence in measurement accuracy when the radial pulse does not coincide with the pulse displayed on the oximeter. It is also important to note that the pulse oximeter device cannot provide an accurate reading when oxygen saturation is below 75% (Shah & Shelley, 2013). Oxygen saturation levels in the 70s indicate that a client is decompensating, and immediate intervention is required. Thus, it is important to confirm accuracy via additional assessments, such as assessing for respiratory distress, drawing arterial blood gases and/or checking for machine error.

The significance of the oxygen saturation level is interpreted in the context of the client's baseline measurements, other data, including vital signs and other objective and subjective findings, and the client's overall health and wellness state.

Next, you have an opportunity to watch the next short film clip on accurate measurement techniques (*Film Clip 1*).



Example: Oxygen Saturation Taken Correctly

Film clip 1: Oxygen saturation taken correctly

Video: “Oxygen Saturation – Taken Correctly” by Toronto Metropolitan University [1:38] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Video Description and Transcript

This interactive video demonstrates the correct technique for measuring oxygen saturation using a pulse oximeter. The video shows a pulse oximeter being applied to a client to obtain an oxygen saturation reading and pulse reading.

Video description: A healthcare provider uses a pulse oximeter to assess oxygen saturation. The device is attached to the client, and the provider waits for the monitor to display an oxygen saturation level and pulse reading. The technique emphasizes using the reading in combination with the client’s overall assessment findings and checking that the pulse displayed on the oximeter aligns with the client’s radial pulse.

Interactive question 1: Fill in the missing numbers.

The expected oxygen saturation range for this client would be between **97%** and **100%**.

Interactive question 2: Which of the following are true about oxygen saturation? Choose all that apply.

- Hemoglobin molecules can each carry five oxygen molecules. **Incorrect.**
- Insufficient oxygen in the blood is called hypohemoglobine. **Incorrect.**
- A pulse oximetry device includes a sensor that measures light absorption of hemoglobin. **Correct.**
- A pulse oximeter reading reflects venous oxygen saturation levels. **Incorrect.**
- The significance of the oxygen saturation level is interpreted within the client context. **Correct.**

Summary: The activity reinforces that pulse oximetry measures arterial oxygen saturation using a sensor, and that the reading should be interpreted in relation to the client’s baseline, health status, and other assessment findings.

Test Your Knowledge

Quiz Text Description

1. Blanks Activity

The client’s oxygen saturation level is ____% and the pulse is ____ beats per minute.

2. MultiChoice Activity

Which vital sign measurement should the nurse measure while the pulse oximeter is on the client’s

finger?

- a. Pulse
- b. Respiration
- c. Pain assessment
- d. Blood pressure

3. MultiChoice Activity

Which conditions can lead to inaccurate oxygen saturation measurements when the device is attached to a finger or toe? Select all that apply.

- a. Ear infections
- b. Peripheral vasoconstriction
- c. Amblyopia
- d. Irritable bowel syndrome
- e. Urinary tract infection
- f. Poor circulation
- g. Hypothermia

Solution:

1. The client's oxygen saturation level is **98%** and the pulse is **75** beats per minute.
2. a. Pulse
3. b. Peripheral vasoconstriction; f. Poor circulation; g. Hypothermia;

From Theory to Practice

Measuring oxygen saturation via pulse oximetry is a non-invasive way to quickly assess a client's oxygen level. The results reflect a person's oxygenation status and provide data for healthcare providers' diagnostic reasoning.

The sensor can be attached in many ways, including clipping and taping probes to the finger, toe, earlobe, and forehead. The type and location of the apparatus are selected based on the client's age, the presence of vasoconstriction, the adequacy of peripheral perfusion, whether intermittent or continuous monitoring is required, and the client's health and illness state.

When determining the relevance of the oxygen saturation reading, healthcare providers consider the client's health and wellness state. Specifically, they consider other data related to oxygenation, including respiratory quality, rate, and rhythm; pulse; skin colour and temperature; and the client's subjective description of ease or difficulty breathing. Decreases in oxygen saturation readings are potentially life-threatening and require immediate intervention.



Activities: Test Your Understanding

Now you have an opportunity to find errors in measurement techniques. The first activity involves watching a short film clip. Check it out!

Activity 1

What error in technique is this healthcare provider making while measuring oxygen saturation in Film clip 2?

Film clip 2 Oxygen saturation taken incorrectly

Video: “Oxygen Saturation – Taken Incorrectly” by Toronto Metropolitan University [1:00] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Text Description

This activity contains a set of dialogue cards, which are described below.

Activity Description or Instruction:

1. In the film clip, what error in technique is this healthcare provider making while measuring oxygen saturation?

Solution:

1. The healthcare provider did not confirm the accuracy of the pulse displayed on the pulse oximeter with the radial pulse. Healthcare providers always assess the radial pulse and ensure that it coincides with the pulse displayed on the oximeter to ensure the accuracy of the oxygen saturation level.

Activity 2

Now you have an opportunity to find errors in measurement techniques by looking at an image.

Which image shows the correct technique while measuring oxygen saturation?

Image Description

The H5P image juxtaposition compares two images related to pulse oximeter technique. Learners can move the slider to compare Image A and Image B.

- **Image A:** A nurse holds a pulse oximeter in front of a patient sitting in bed. The probe is on the table near the patient's hand and is not correctly attached to the patient's finger.
- **Image B:** A nurse holds the pulse oximeter while the probe is correctly placed on the patient's fin-

ger. The monitor displays an oxygen saturation reading and pulse rate.

The comparison helps learners recognize that the pulse oximeter probe must be properly placed on the patient's finger to obtain an accurate oxygen saturation and pulse reading.

Activity 3

Text Description

The correct technique for taking an oxygen saturation measurement is Image ____.

Solution:

The correct technique for taking an oxygen saturation measurement is Image **A**.

Activity 4

Text Description

Which Image is Correct?

An **incorrect technique** is demonstrated in Image B because the healthcare provider is using the pulse oximeter device on a client who has nail polish on her fingers. Nail polish can affect accuracy, so healthcare providers remove nail polish when pulse oximetry is measured on the fingers. Alternatively, the oxygen saturation could be measured using a device attached to the earlobe.

The **correct technique** is demonstrated in Image A, in which the nail polish is removed. It is also important to note that healthcare providers need to ensure the radial pulse aligns with the pulse displayed on the pulse oximeter.

Solution:

Text Description

Which Image is Correct?

An **incorrect technique** is demonstrated in Image B because the healthcare provider is using the pulse oximeter device on a client who has nail polish on her fingers. Nail polish can affect accuracy, so healthcare providers remove nail polish when pulse oximetry is measured on the fingers. Alternatively, the oxygen saturation could be measured using a device attached to the earlobe.

The **correct technique** is demonstrated in Image A, in which the nail polish is removed. It is also important to note that healthcare providers need to ensure the radial pulse aligns with the pulse displayed on the pulse oximeter.

Activity 5

Now that you have completed the O₂ saturation content, it's time to test your knowledge. Try to answer the following questions.

Text Description

Match each person with the estimated SpO₂.

1. Health adolescent _____
2. Adult with lung disease _____
3. 80-year-old adult _____

Possible answers:

- 92% SpO₂
- 95% SpO₂
- 97% SpO₂

Solution:

1. Health adolescent **97% SpO₂**
2. Adult with lung disease **92% SpO₂**
3. 80-year-old adult **95% SpO₂**

Activity 6

Text Description

A client's oxygen saturation is measured via pulse oximetry using a finger probe. The radial pulse does not coincide with the pulse displayed on the oximeter. How should the healthcare provider respond?

- a. Repeat the measurements using an earlobe probe.
- b. Assume the client has hypoxic tissue injury.
- c. Document the findings in the client's chart.
- d. Notify the most responsible provider.

Solution:

Correct answer(s): a. Repeat the measurements using an earlobe probe.

Activity 7

Text Description

The physician asks for an oxygen saturation report on a client who has peripheral limb tremors. What is the best location to place the probe?

- a. Finger
- b. Thumb
- c. Ear
- d. Toe

Solution:

Correct answer(s): c. Ear

Activity 8

Text Description

A person's oxygen saturation is 89%, and the pulse display on the pulse oximeter is aligned with the radial pulse. How should the healthcare provider respond?

- a. Raise up the head of the client's bed.
- b. Give oxygen to the client.
- c. Ask the client, "Are you having any difficulty breathing?"
- d. Note this finding as normal and continue with your assessment.

Solution:

Correct answer(s): c. Ask the client, "Are you having any difficulty breathing?"

Text Description

List the steps below in the correct order.

1. ____ Take radial pulse (30 seconds if regular and 1 minute if irregular).
2. ____ Clean oximeter probe with alcohol swab.
3. ____ Document or report findings.
4. ____ Turn pulse oximeter on.
5. ____ Clip or tape probe onto the client's finger.
6. ____ Remove the client's nail polish.
7. ____ Ensure radial pulse is aligned with pulse on the pulse oximeter.

Possible answers:

- 3.
- 6.
- 1.
- 2.
- 7.
- 5.
- 4.

Solution:

1. **5.** Take radial pulse (30 seconds if regular and 1 minute if irregular).
2. **2.** Clean oximeter probe with alcohol swab.
3. **7.** Document or report findings.
4. **4.** Turn pulse oximeter on.
5. **3.** Clip or tape probe onto the client's finger.
6. **1.** Remove the client's nail polish.
7. **6.** Ensure radial pulse is aligned with pulse on the pulse oximeter.

Activity 9

Text Description

Which areas can a pulse oximeter sensor be attached on a person's body? Select all that apply.

- a. Toe
- b. Forearm
- c. Neck
- d. Forehead
- e. Ankle
- f. Earlobe
- g. Finger

Solution:

Correct answer(s): a. Toe; d. Forehead; f. Earlobe; g. Finger;

Activity 10

Text Description

Drag the words into the correct boxes.

Measuring oxygen saturation is a _____ to quickly assess a client's _____. The nurse must consider other data related to oxygenation including respiratory quality; pulse; _____; and _____; and the client's _____. Decreases in oxygen saturation readings are potentially _____ and require _____.

Possible answers:

- skin colour
- temperature
- oxygenation status
- subjective description
- life-threatening
- non-invasive way
- immediate intervention

Solution: Measuring oxygen saturation is a **non-invasive way** to quickly assess a client's **oxygenation status**. The nurse must consider other data related to oxygenation, including respiratory quality, pulse, **temperature**, and **skin colour**, and the client's **subjective description**. Decreases in oxygen saturation readings are potentially **life-threatening** and require **immediate intervention**.

This section has been adapted from “Chapter 7: Vital Signs” in Introduction to Health Assessment for the Nursing Professional (2024) – Canadian edition Copyright © by Lapum and Hughes is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted.

6.6 Blood Pressure

What is Blood Pressure?

Blood pressure is the force of blood exerted against the arterial walls, and is reported in millimetres of mercury (mm Hg). Try turning your kitchen tap on just a little bit, and then full blast. Compare the varying forces of water pressure as you adjust the tap. This comparison will give you a better sense of blood pressure.

The pressure against the arterial walls (the blood pressure) changes depending on whether the heart is contracting and pushing blood out into the arteries or whether the heart is in a resting phase and filling with blood. There is always a force against the arterial walls, even when the heart is in a resting phase. The *systolic pressure* is the maximum pressure on the arteries during left ventricular contraction (systole). The left ventricle is a lower chamber of the heart responsible for pumping blood out to the body. The *diastolic pressure* is the resting pressure on the arteries between each cardiac contraction when the heart's chambers are filling with blood (diastole).

Stroke volume is the amount of blood ejected from the left ventricle in a single contraction. Stroke volume provides information about the functioning of the heart. Stroke volume is influenced by age and typically ranges from 5–80 mL. Newborns have a stroke volume of about 5 mL per contraction, while adults have a stroke volume of about 30–70 mL per contraction; the stroke volume increases as individuals grow and their hearts become stronger and can pump more volume per contraction. Direct measurement of stroke volume involves an invasive approach in which a catheter is passed into the pulmonary artery via a large neck vein; this monitoring device is only used during critical care situations.

Indirect measurement of stroke volume involves assessing the *pulse pressure*, which is the difference between the systolic and diastolic values and signifies the force required by the heart each time it contracts. For example, if someone's blood pressure is 120/80 mm Hg, the pulse pressure is 40 mm Hg. A higher pulse pressure can indicate arterial stiffness, which often happens as a result of aging or cardiovascular disease. A higher pulse pressure can also be indicative of aortic valvular insufficiency, where the diastolic pressure is unusually low, and the systolic pressure is mildly elevated or unchanged. A lower pulse pressure can be a marker of poor heart function, where cardiac output is decreased.

Why is Blood Pressured Measured?

- A person's blood pressure provides insight into the functioning of the body
- Healthy body functioning is influenced by healthy blood pressure
- The findings can provide information about the integrity of arteries and heart functioning, which can lead the healthcare provider to conduct additional assessments
- High blood pressure can cause the arteries to become weak and damaged, and cause the heart to become weak and enlarged
- Low blood pressure can decrease perfusion of nutrients and oxygen to the body's cells, influencing the ability to function and potentially leading to cellular death
- Chronic high blood pressure can contribute to conditions such as vascular disease, myocardial infarction, cerebral stroke, kidney disease, and dementia



Activity: Test Your Understanding

Please answer the four questions in the following question set.

Quiz Text Description

1. Blanks Activity

Blood pressure is reported in ____ of ____ (____).

2. DragText Activity

Drag and drop the definition to the correct term.

1. ____ the force of blood exerted against the arterial walls
2. ____ the maximum pressure on the arteries during left ventricular contraction
3. ____ the resting pressure on the arteries between each cardiac contraction when the heart's chambers are filling with blood
4. ____ the amount of blood ejected from the left ventricle in a single contraction
5. ____ the difference between the systolic and diastolic values

Possible answers:

- Blood pressure
- Pulse pressure
- Diastolic pressure
- Systolic pressure
- Stroke volume

3. Blanks Activity

Calculate the pulse pressure for a blood pressure of 145/70. ____ mm Hg

4. TrueFalse Activity

A higher pulse pressure is a marker of poor heart function, while a lower pulse pressure can indicate arterial stiffness. (True/False)

6.6.1 Factors That Influence Blood

Five factors influence blood pressure:

1. Cardiac output
2. Peripheral vascular resistance
3. Volume of circulating blood

4. Viscosity of blood
5. Elasticity of vascular walls

Blood pressure increases with increased cardiac output, peripheral vascular resistance, blood volume, blood viscosity, and vessel wall rigidity.

Blood pressure decreases with decreased cardiac output, peripheral vascular resistance, blood volume, and blood viscosity. Blood pressure will also decrease when the vessel walls are more elastic.

Cardiac Output

Cardiac output is the volume of blood pumped by the heart through the ventricles and is usually measured in litres per minute (L/min). Cardiac output can be calculated as stroke volume multiplied by heart rate. Any factor that causes cardiac output to increase, by elevating heart rate or stroke volume or both, will elevate blood pressure and promote blood flow. These factors include sympathetic stimulation, the catecholamines epinephrine and norepinephrine, thyroid hormones, and increased calcium ion levels. Conversely, any factor that decreases cardiac output, by decreasing heart rate or stroke volume or both, will decrease arterial pressure and blood flow. These factors include parasympathetic stimulation, elevated or decreased potassium ion levels, decreased calcium levels, anoxia, and acidosis.

Peripheral Vascular Resistance

Peripheral vascular resistance refers to compliance, which is the ability of any compartment to expand to accommodate increased content. A metal pipe, for example, is noncompliant, whereas a balloon is compliant. The greater the compliance of an artery, the more effectively it can expand to accommodate surges in blood flow without increasing resistance or blood pressure. Veins are more compliant than arteries and can expand to hold more blood. When vascular disease causes arterial stiffening (e.g., atherosclerosis or arteriosclerosis), compliance decreases and resistance to blood flow increases. The result is more turbulence, higher pressure within the vessel, and reduced blood flow. This increases the heart's workload.

Volume of Circulating Blood

Volume of circulating blood is the amount of blood moving through the body. Increased venous return stretches the walls of the atria, where specialized baroreceptors are located. Baroreceptors are pressure-sensing receptors. As atrial baroreceptors increase their firing rate and stretch with increased blood pressure, the cardiac centre responds by reducing sympathetic stimulation and increasing parasympathetic stimulation to decrease HR. The opposite is also true.

Viscosity of Blood

Viscosity of blood is a measure of the blood's thickness and is influenced by the presence of plasma proteins and formed elements in the blood. Blood is viscous and somewhat sticky to the touch. It has a viscosity approximately five times greater than water. Viscosity is a measure of a fluid's thickness or resistance to flow, and is influenced by the presence of the plasma proteins and formed elements within the blood. The viscosity of blood has a dramatic effect on blood pressure and flow. Consider the difference in flow between water and honey. The more viscous honey would demonstrate a greater resistance to flow than the less viscous water. The same principle applies to blood.

Elasticity of Vessel Walls

Elasticity of vessel walls refers to the capacity to resume its normal shape after stretching and compressing. Vessels larger than 10 mm in diameter are typically elastic. Their abundant elastic fibres allow them to expand as blood pumped from the ventricles passes through them, and then to recoil after the surge has passed. If artery walls were rigid and unable to expand and recoil, their resistance to blood flow would greatly increase, and blood pressure would rise to even higher levels, which would in turn require the heart to pump harder to increase the volume of blood expelled by each pump (the stroke volume) and maintain adequate pressure and flow. Artery walls would have to become even thicker in response to this increased pressure.



Activity: Test Your Understanding

Please answer the two questions in the following question set.

Quiz Text Description

1. Blanks Activity

Blood pressure increases with ____ cardiac output, peripheral vascular resistance, volume of blood, viscosity of blood and rigidity of vessel walls.

Blood pressure decreases with ____ cardiac output, peripheral vascular resistance, volume of blood, and viscosity of blood.

2. DragText Activity

Drag the descriptions to the correct factor influencing blood pressure.

1. ____ is the volume of blood flow from the heart through the ventricles, and is usually measured in litres per minute (L/min).
2. ____ refers to compliance, which is the ability of any compartment to expand to accommodate increased content.
3. ____ is the amount of blood moving through the body.
4. ____ is a measure of the blood's thickness and is influenced by the presence of plasma proteins and formed elements in the blood.
5. ____ is the capacity to resume its normal shape after stretching and compressing.

Possible answers:

- Viscosity of blood
- Elasticity of vessel walls
- Cardiac output
- Peripheral vascular resistance
- Volume of circulating blood

Solution:

1. Blood pressure increases with **increased** cardiac output, peripheral vascular resistance, volume of blood, viscosity of blood and rigidity of vessel walls. Blood pressure decreases with **decreased** cardiac output, peripheral vascular resistance, volume of blood, and viscosity of blood.
2. **Cardiac output** is the volume of blood flow from the heart through the ventricles, and is usually measured in litres per minute (L/min).
3. **Peripheral vascular resistance** refers to compliance, which is the ability of any compartment to expand to accommodate increased content.
4. **Volume of circulating blood** is the amount of blood moving through the body.

5. **Viscosity of blood** is a measure of the blood's thickness and is influenced by the presence of plasma proteins and formed elements in the blood.
6. **Elasticity of vessel walls** is the capacity to resume its normal shape after stretching and compressing.

6.6.2 Blood Pressure Ranges

Blood pressure is reported in mm Hg (pronounced millimetres of mercury), in which the systolic is the numerator and the diastolic is the denominator. In adults (18 years and older), *normal blood pressure* typically ranges from *90 to less than 130 mm Hg* (systolic) and *60 to less than 80 mm Hg* (diastolic). Blood pressure typically rises with age because of the stiffening of arteries and plaque build-up.

The focus of this chapter is adult clients, but it is important to note that, like BMI, normative blood pressure ranges in children are based on **percentile readings** as related to age, sex, and height (Dionne et al., 2017). Generally, BP readings greater than the 90th percentile are considered elevated and greater than the 95th percentile are considered hypertension. Here is an example of BP percentiles for:

- female children: BP Levels for Girls by Age and Height Percentile [PDF]
- male children: BP Levels for Boys by Age and Height Percentile [PDF]

However, a simplified rule of thumb is that a BP of greater than 120/80 mm Hg in those six to 11 years of age and a BP of greater than 130/85 mm Hg in those 12 to 17 years of age should be of concern (Rabi et al., 2020).

Points of Consideration

In evaluating whether a client's BP is normal, it is also important to consider the client's baseline blood pressure and the client's current health state in conjunction with subjective data and other objective data. For example, a blood pressure of 88/50 mm Hg may be normal for a healthy, asymptomatic 20-year-old adult.

Factors that influence blood pressure include age, sex, ethnicity, weight, exercise, emotions/stress, pregnancy, and diurnal rhythm, as well as medication use and disease processes.

- The general pattern is that blood pressure rises with age, so normal variations tend to be higher for older adults.
- Blood pressure is similar in childhood for males and females. After puberty, females have lower blood pressure than males, whereas after menopause, females have higher blood pressure than males.
- Research has revealed that ethnicity may be a predictor of blood pressure, but this causation is not necessarily biological, but rather sociocultural. When determining risk for high blood pressure, it is important to consider ethnicity as a contributing factor.
- The diurnal cycle influences blood pressure to be lower in the morning and increase throughout the day until early evening. Try it out: take your blood pressure when you wake up in the morning and then again in late afternoon, and note the difference. This is one reason why healthcare providers document the time

a client's blood pressure is taken.

- Blood pressure can be higher in people who are obese because the heart has to work harder to perfuse the body's tissues.
- The sympathetic nervous system is stimulated by exercise, stress, anxiety, pain, anger, and fear, which increases blood pressure. Blood pressure returns to baseline within five minutes of rest following activity. Try it out. Have a peer take your blood pressure. Then, run on the spot or do some other cardio activity for five minutes. Have the peer take your blood pressure again, and then lie down and rest for five minutes. Take the blood pressure again. Note the changes.
- Blood pressure varies throughout the duration of pregnancy. It decreases about halfway through the first trimester until mid-pregnancy due to progesterone effects that relax the walls of blood vessels, causing decreased peripheral vascular resistance. It returns to pre-pregnancy values toward the end of pregnancy.

In evaluating whether a client's BP is normal, it is also important to consider the client's baseline blood pressure and the client's current health state in conjunction with subjective data and other objective data. For example, a blood pressure of 88/50 mm Hg may be normal for a healthy, asymptomatic 20-year-old adult.

Points of Consideration

White coat syndrome refers to elevated blood pressure due to nervousness or anxiety when clients have their blood pressure taken by a healthcare provider. This occurs in approximately 20% of clients. Key message: Have the client take their blood pressure at home with an automatic home blood pressure cuff and compare the findings. Alternatively, you can ask the client to sit quietly and leave the room while an automatic cuff takes the client's blood pressure. The automatic cuff can be programmed to take three measurements, and the blood pressure documented is an average of the three readings.



Activities: Test Your Understanding

Text Description

A BP of 124/76 mm Hg in a client who is 50 years of age. How should the nurse identify this cue?

- a. Normal
- b. Abnormal

Solution:

Correct answer(s): a. Normal

Text Description

Which cue is a priority of care?

- a. BP of 128/78 mm Hg in a 55 year old client
- b. BP of 142/86 mm Hg in a 26 year old client
- c. BP of 92/60 mm Hg om a 20 year old client
- d. BP of 126/80 mm Hg in a 66 year old client
- e. BP of 112/74 mm Hg in a 45 year old client

6.6.3 How is Blood Pressure Measured?

Blood pressure is measured in many ways, including manual/auscultatory, automatic/electronic, cellular phone applications, and arterial catheters. Whatever method is used, blood pressure must be measured using *validated equipment*. It has been found that blood pressure is often not measured accurately in clinical practice, particularly when using the auscultatory/manual method. It is important to ensure the correct technique to obtain an accurate measurement. Hypertension Canada (Goupil et al., 2025) recommends automatic/electronic blood pressure measurement as the preferred method in clinical practice, particularly when diagnosing hypertension; however, if a validated automatic machine is not available or arrhythmias are present, then manual BP is recommended. Automatic blood pressure methods should not be used when the pulse force is weak (difficult to feel), and the pulse rhythm is irregular; these situations can result in inaccurate blood pressure measurements with automatic machines.

Points of Consideration

If a BP is high, it is often best to check it again for accuracy. Then, take blood pressure in both arms when

you measure a client's blood pressure for the first time. A small difference in blood pressure between the arms is often normal. Differences of greater than 10 mm Hg systolic between the arms are investigated further because this finding has been associated with vascular disease and mortality outcomes. Measure subsequent blood pressures in the arm with the higher blood pressure.

Client Positioning

Blood pressure is generally taken in a sitting or supine position with the bare arm at heart level. Certain health states prevent some clients from sitting, such as clients who are critically ill, unstable, or postoperative. Thus, healthcare providers document the client's positioning (e.g., sitting, supine, standing). *If sitting*, the feet are placed flat on the floor with the back resting comfortably against a chair. The healthcare provider checks to ensure that the client's legs are not crossed, because this can increase blood pressure. The client sits resting for five minutes before you take the blood pressure. *This waiting period is not feasible when the client's condition is deteriorating, or a STAT blood pressure is required.* Because the client should be resting, you should ask them not to talk or move. Additionally, you should not ask them to hold any of your equipment during the blood pressure measurement.

Cuff Types and Sizes

Manual and automatic blood pressure measurement involve using a blood pressure cuff with a sphygmomanometer. Many cuff sizes are available to fit newborns, children, adults, people with small and larger arms, and people with cone-shaped arms. The cuff is typically wrapped around the upper arm. However, there is also a cuff that can be placed on the thigh when the arm is not feasible. See *Figure 6.6.1* of varying blood pressure cuff sizes. Wrist devices can be used for blood pressure estimation when clients have a large upper arm circumference (Rabi et al., 2020). When taking the measurement, make sure that the arm and wrist are supported at heart level (Rabi et al., 2020).



Figure 6.6.1: Varying blood pressure cuff sizes

It is important to choose a cuff size that matches the client's arm size, rather than their age. See *Table 6.6.1* about cuff sizing. See *Film Clip 1* of a demonstration of accurate cuff sizing.

Table 6.6.1

Cuff Sizing
The width of the cuff is 40% of the person's arm circumference
The length of the cuff's bladder is 80–100% of the person's arm circumference



Watch: Blood Pressure – Accurate Cuff Sizing

Film Clip 1: " by Toronto Metropolitan University [1:03] is licensed under the Standard YouTube License
.Transcript and closed captions available on YouTube.

Before placing the blood pressure cuff on the client's arm, *palpate the brachial artery* using three fingers (not

your thumb) just above the antecubital fossa medially (OER #1). To do this, palpate the bicep tendon at the antecubital fossa. Move 2 cm medially from the tendon and 3 cm above the antecubital fossa. Press firmly to feel the brachial pulse. Wrap the blood pressure cuff securely and evenly around the client's upper, bare arm (not over clothing) with the *cuff's artery marker aligned with the brachial artery and 3cm above the antecubital fossa*. Hypertension Canada (Goupil et al., 2025) recommends that the *middle of the cuff should be at the level of the heart*.



Technique Tips

Thigh blood pressure is indicated when blood pressure cannot be taken on the arm, such as when clients have bilateral amputation or burns. Thigh blood pressure is also done on children and adolescents with unusually high blood pressure in the arm and to compare differences between upper and lower extremities. In such cases, coarctation of the aorta (a congenital narrowing of the aorta) is possible. The thigh systolic blood pressure is 10–40 mm Hg higher than the arm systolic blood pressure, while the thigh diastolic blood pressure is approximately the same as the arm. To obtain thigh blood pressure, the client must be in the prone position. Place the cuff around the bottom third of the client's thigh. The cuff's artery line is aligned with the popliteal artery. The popliteal artery can be located in the popliteal fossa. Palpate the medial tendon and move the pads of your three fingers lateral to the tendon. Press your fingers into the femur or tibia bone. Continue with the same process as noted above in terms of taking blood pressure.

Blood Pressure Methods

Manual blood pressure measurement is taken using a blood pressure cuff with a sphygmomanometer and a stethoscope. See *Figure 6.6.2*.



Figure 6.6.2: Blood pressure cuff with a sphygmomanometer and a stethoscope

Automatic blood pressure cuffs are a digital way to measure blood pressure. See Figure 6.6.3. After positioning the client and the blood pressure cuff on the arm, press the start button on the monitor. The cuff is automatically inflated and then deflates at a rate of 2 mm Hg per second. The monitor has a digital display that shows the blood pressure reading when done. Automatic cuffs can be programmed to take a series of blood pressure readings in a row. If the healthcare provider is concerned about an *initial high blood pressure* reading on a client, the accuracy of the blood pressure is verified with the following actions:

- have the client sit in a room by themselves
- quiet the room
- dim the lights
- allow the client to sit quietly, without talking, for five minutes.
- then take three measurements, one minute apart, with the automatic cuff. The blood pressure displayed is an average of the three readings.

There are cues that may prompt you to do a manual BP after an automatic BP, such as when the findings are outside of the client's baseline, the findings are abnormal, a diastolic does not register on the machine, or with a client who struggles to keep their arm still and straight.



Figure 6.6.3: Automatic blood pressure cuff. The monitor displays a blood pressure reading and pulse rate.

Clients can monitor their blood pressure at home with an automatic digital blood pressure monitor. Clients are advised to use a device that meets the standards of the Association for the Advancement of Medical Instrumentation, the requirements of the British Hypertension Society protocol, or the International Protocol for Validation of Automated Blood Pressure Measuring Devices. The cuff is applied around the client's upper arm or wrist. Similar to the automatic cuff noted above, the client presses the start button, and the cuff inflates and deflates based on programmed levels, displaying a digital reading. Clients are encouraged to document their blood pressure or use a device with data-recording capabilities to increase the reliability of their reported home blood pressure monitoring. These data can be shared with the client's primary care provider.

Arterial catheters are an invasive method for measuring blood pressure and are used only in critical care situations when continuous blood pressure monitoring and arterial blood gas sampling are required. This involves the insertion of a catheter (similar to an intravenous catheter) into the artery. The catheter is connected to a pressure transducer and monitor that provides a digital blood pressure reading.

Cellular phone applications have been developed to measure blood pressure, but the accuracy of this technology is still being investigated.

Points of Consideration

Avoid using an automatic blood pressure cuff if the systolic pressure is less than 90 mm Hg in an adult, the pulse is rapid, the rhythm is irregular (e.g., arrhythmia), and/or the client is experiencing shivering or tremors. It is also best to complete a manual blood pressure measurement to validate the accuracy of the automatic reading.

6.6.4 Manual Blood Pressure Measurement

A healthcare provider uses a stethoscope and a blood pressure cuff with a sphygmomanometer to measure blood pressure manually. The stethoscope is used to listen to the blood pressure sounds, which are called Korotkoff sounds.

Stethoscope Usage and Korotkoff Sounds

The stethoscope is used on *bare skin* so that a client's clothing does not affect the sounds. The stethoscope does not make sounds louder; it simply blocks out extraneous noises so you can better hear the Korotkoff sounds. These sounds are heard through a stethoscope applied over the brachial artery when the blood pressure cuff is deflating. You will not hear anything when you first place the stethoscope over the brachial artery because unobstructed blood flow is silent. The Korotkoff sounds appear after you inflate the cuff (which compresses the artery/blood flow) and then begin to deflate the cuff. The Korotkoff sounds are the result of the turbulent blood caused by the inflated cuff compressing the artery and oscillations of the arterial wall when the heart beats during cuff deflation.

Here are a few tips:

- Use a high-quality stethoscope with durable, thick tubing. Avoid stethoscopes with long tubing because this can distort sounds.
- Ensure quiet surroundings so that you can better hear the Korotkoff sounds.
- Make sure that the slope of the stethoscope earpieces points forward or toward your nose.
- Use a stethoscope that has both bell and diaphragm capacity. See *Figure 6.6.4* for bell and diaphragm.



Figure 6.6.4: Stethoscope with bell and diaphragm (Illustration credit: Hilary Tang).

- Cleanse the stethoscope prior to use, including the ear pieces and the bell and diaphragm.
- The bell of the stethoscope is suggested because it is used for low-pitched sounds like blood pressure. However, some healthcare providers use the diaphragm for several reasons: that is how they learned to take blood pressure; they believe this helps them hear the Korotkoff sounds better; and the diaphragm covers a larger surface area than the bell.
- Hold the bell lightly against the skin with a complete seal, or hold the diaphragm firmly against the skin with a complete seal.
- You must ensure that the bell or diaphragm is open before using. See *Film Clip 2* on how to open and close the bell and diaphragm.



Watch: Stethoscope – Bell & Diaphragm

Film Clip 2: “Stethoscope – Bell & Diaphragm – How to Open and Close” by Toronto Metropolitan University [1:41] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Determining Maximum Inflation Pressure

Healthcare providers determine the maximum inflation pressure before they take blood pressure. The maximum inflation pressure is the number on the sphygmomanometer that the cuff is inflated to when measuring blood pressure. If you do not determine the maximum pressure inflation, an auscultatory gap could go unrecognized, and as a result, the blood pressure could be underestimated (lower than the actual value).

An *auscultatory gap* is a silent interval when the Korotkoff sounds go absent and then reappear while you are deflating the cuff during blood pressure measurement. This gap is an abnormal finding and can occur due to arterial stiffness and arteriosclerotic disease. It is typically observed in people with a history of hypertension who have been treated with prolonged antihypertensive medication.

To determine the maximum inflation pressure, start by palpating the brachial or radial pulse while inflating the cuff. Inflate the cuff 30 mm Hg quickly past the point when you obliterate the pulse (ie, you no longer feel the pulse). If you still cannot feel the pulse, use that value to start auscultating – that value is the maximum inflation pressure number.

When taking blood pressure, if an auscultatory gap is observed, document the first systolic sound and diastolic sound only. Report the presence of an auscultatory gap in narrative notes.

Points of Consideration

Generally, auscultatory gaps do not interfere with automatic blood pressure measurements (Fech et al., 2012). However, if a client's blood pressure reading is suspiciously high or low, the healthcare provider takes the blood pressure manually.

Blood Pressure Measurement Techniques

For novices, it is a good idea to start with the two-step technique and then move on to the one-step technique as you develop your skills.

Two-step Technique

Step #1: Determining Maximum Pressure Inflation

Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is obliterated, and then continue to inflate 30 mm Hg more (OER #1). Note this number – it is considered the maximum pressure inflation. Next, deflate the cuff quickly by fully opening the valve.

Step #2: Measure Blood Pressure

Now, you can start to measure blood pressure. Place the bell of the cleansed stethoscope over the brachial artery using a light touch and a complete seal. Inflate the cuff to the maximum pressure inflation number (OER #1). Open the valve slightly. Deflate the cuff slowly and evenly at about 2 mm Hg per second. See *Film Clip 3*, which focuses on the speed of the needle when deflating the blood pressure cuff.

Note the points at which you hear the first appearance of Korotkoff sounds (systolic blood pressure) and the point at which the Korotkoff sounds go silent (diastolic blood pressure) (Hypertension Canada, 2020). These sounds are called Korotkoff sounds and vary in quality from tapping, swooshing, muffled sounds, and silence. The pressure at which the first Korotkoff sound is noted signifies the systolic pressure, while the pressure at which the Korotkoff sounds are no longer heard marks the diastolic pressure. See *Audio Clip 1* to listen to Korotkoff sounds and note systolic and diastolic blood pressure.



Watch: Deflation Rate of Sphygmomanometer

Film Clip 3: “Blood Pressure – Deflation Rate” by Toronto Metropolitan University [1:17] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Next, you have the opportunity to observe the two-step blood pressure approach and then try it out yourself – see *Film Clip 4*. This approach is best used when you are first learning how to take blood pressure.



Watch: Blood Pressure – Two Step Method

Film Clip 4: “Blood Pressure – Two Step Method” by Toronto Metropolitan University [4:39] is licensed under the Standard YouTube License. *Transcript and closed captions available on*

(**NOTE:** The *diastolic* is the point at which the *Korotkoff sounds go silent* [Hypertension Canada, 2025]. Please note that this video was taken prior to the release of these new guidelines. In addition, place the cuff 3cm above the antecubital fossa.)



Watch: Blood Pressure – Korotkoff Sounds

Video: “Blood Pressure – Korotkoff Sounds I” by Toronto Metropolitan University [1:02] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Audio Clip 1: Korotkoff sounds during blood pressure measurement.

Text Description

The blood pressure measurement reading in **Audio clip 1 (6.6)** is:

- a. 138/78 mm Hg
- b. 140/80 mm Hg
- c. 122/74 mm Hg
- d. 121/78 mm Hg

One-step technique: Determining maximum pressure inflation and taking blood pressure

Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is obliterated, and then continue to quickly inflate 30 mm Hg more (Hypertension Canada, 2020). Place the bell of the cleansed stethoscope over the brachial artery using a light touch with a complete seal. Open the valve slightly. Deflate the cuff slowly and evenly at about 2 mm Hg per second. Note the points at which you hear the first Korotkoff sound (systolic blood pressure) (OER #1) and the point at which the Korotkoff sounds go silent (diastolic blood pressure) (Hypertension Canada, 2020). These sounds are called Korotkoff sounds and vary in quality from tapping, swooshing, muffled sounds, and silence. The first Korotkoff sound is the systolic pressure, and the diastolic pressure is when the Korotkoff sounds go silent.



Watch: Blood Pressure – One Step Method

Watch this teaching video of a film clip that shows the *one-step blood pressure approach* – see *Film Clip 5*. After you become proficient in the two-step approach, you can move on to the one-step blood pressure approach.

Film Clip 5: “Blood Pressure – One Step Method” by Toronto Metropolitan University [3:55] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

(**Note:** the Hypertension Canada 2025 guidelines now indicate that the cuff should be placed 3cm above the antecubital fossa).

Points of Consideration

Korotkoff sounds are the sounds of blood flow through the artery as you are listening to blood pressure. Korotkoff sounds are not the same thing as the heartbeat or the pulse. They disappear as the cuff is inflated and reappear as the cuff is deflated. They also cannot be heard when the cuff is fully deflated because unobstructed and healthy blood flow is silent. When deflating the cuff, the first Korotkoff sound is systolic, and the point at which the Korotkoff sounds are no longer heard is diastolic (Hypertension Canada, 2020). In rare cases, the Korotkoff sounds continue to 0 mm Hg. In this case, the diastolic pressure should be measured when the Korotkoff sounds become muffled (Hypertension Canada, 2020).



Activity: Test Your Understanding

Text Description

MultiChoice Activity

1. When do you hear Korotkoff sounds during blood pressure measurement?
- a. Upon inflation of the blood pressure cuff.
 - b. Upon deflation of the blood pressure cuff.
 - c. At the maximum inflation pressure.
 - d. When you first place the stethoscope over the brachial artery.

TrueFalse Activity

2. The stethoscope can be used on bare skin or over clothing. (True/False)

MultiChoice Activity

3. What is the auscultatory gap?
- a. The silent interval when the Korotkoff sounds go absent.
 - b. The point at which the Korotkoff sounds go silent.
 - c. The first Korotkoff sound you hear.
 - d. The swishing sound in between the first and last Korotkoff sounds.

Solution:

MultiChoice Activity

Correct answer(s): b. Upon deflation of the blood pressure cuff.

TrueFalse Activity

Correct answer: False

MultiChoice Activity

Correct answer(s): a. The silent interval when the Korotkoff sounds go absent.



Watch: How to Check Blood Pressure

Video: “Blood Pressure Measurement: How to Check Blood Pressure Manually” by RegisteredNurseRN [5:17] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

6.6.5 Blood Pressure Considerations

Manual blood pressure is reported in even numbers. Healthcare providers **always measure blood pressure with pulse** because these vital signs are closely related, and data from both are needed to make accurate and informed clinical decisions.

What Should You Do if You Cannot Feel the Brachial Pulse?

- To locate the brachial pulse, palpate the bicep tendon, move medially about 2 cm, and move up about 2–3 cm
- Use three fingers, including your index and middle fingers, to feel for the pulse
- You will usually need to press fairly firmly to palpate the brachial pulse and may need to modify the pressure. If you press too hard, you will obliterate the pulse (make it disappear), and if you press too lightly, you will not be able to feel the pulse
- You may need to reposition your fingers to find the best place to feel the pulse along the brachial artery
- Place the client’s arm with the palm up and elbow extended. You can flex the elbow in varying degrees to relax the muscle and accentuate the pulse
- Cup your opposite hand under the client’s elbow

What Should You Do if You Cannot Hear the Korotkoff Sounds?

- Use your bell and make full contact with skin
- Make sure the bell is positioned over the brachial artery
- Ensure the room is quiet
- Concentrate on expected sounds (swooshing, tapping, muffled sounds)
- Try different earbuds (hard or soft) on your stethoscope

Common Errors When Taking Blood Pressure

Many errors must be avoided when measuring blood pressure.

- Failure to determine maximum pressure inflation can produce a falsely low systolic reading.
- Deflating the cuff too slowly can produce a falsely high diastolic, and deflating the cuff too quickly can produce a falsely low systolic or falsely high diastolic reading.
- Inaccurate cuff sizes for the client’s arm size and shape can result in measurement error: a cuff that is too

narrow can produce a falsely high blood pressure, whereas a cuff that is too loose can produce a falsely low blood pressure.

- A falsely low blood pressure can result from the arm being positioned above the level of the heart, and a falsely high blood pressure can result from the arm being positioned below the level of the heart.

6.6.6 Hypotension

A number of factors can cause hypotension (low blood pressure). *Hypotension is considered less than 90/60 mm Hg in a normotensive adult.* However, low blood pressure measurements are always interpreted in the context of a client's baseline and past blood pressure readings as well as their current health state. Common symptoms associated with hypotension are lightheadedness, loss of consciousness, blurry vision, nausea, and fatigue.

Orthostatic Hypotension

Orthostatic hypotension is a specific type of hypotension that involves a drop in blood pressure associated with postural changes. Specifically, there is a *drop in blood pressure when the client moves from lying to standing position* (and sometimes from sitting to standing).

Have you ever stood up quickly and felt dizzy for a moment? This is because blood is not getting to your brain, so it is briefly deprived of oxygen. It is appropriate to assess for the presence of orthostatic hypotension when a client reports feeling dizzy, light-headed, or **syncope** when they sit up or stand up, or with a client who has been experiencing falls with no specific cause.

When a person moves from supine to standing, there is a gravitational pull in which a significant amount of blood moves from the core of the body to the periphery (e.g., the legs). Normally, there is a hemodynamic response which maintains venous return and cardiac output; this response involves a slight increase in the heart rate, constriction of the vasculature, and the maintenance of the blood pressure or a slight decrease. This hemodynamic response keeps the brain oxygenated so that cognitive and other neural processes are not interrupted. However, sometimes this response does not work properly.

If the sympathetic system cannot increase cardiac output, then blood pressure decreases, and a neurological loss can be felt. This can be brief, such as a slight dizziness when standing up too quickly, or it could lead to a loss of balance, a fall, and neurological impairment for a period of time. The name for this is *orthostatic hypotension*, which means that blood pressure falls with postural changes from supine to standing. It can be the result of standing up faster than the reflex can occur, which may cause a benign 'head rush,' or it may be the result of an underlying cause.

There are several reasons why orthostatic hypotension occurs, which can be *cardiac* or *neurogenic* related. For example, the blood volume may be too low, and the sympathetic reflex is not effective. This hypovolemia may be the result of dehydration (related to factors such as severe diarrhea or vomiting) or medications that affect fluid balance, such as **diuretics** or **vasodilators**. The second underlying cause of orthostatic hypotension is *autonomic failure*. Several disorders can result in compromised sympathetic functions, ranging from diabetes to multiple system atrophy (a loss of control over many systems in the body), and addressing the underlying condition can improve the hypotension. Orthostatic hypotension is more common with advancing age and can be aggravated by antihypertensive medications.

How to Assess Orthostatic Hypotension

Orthostatic hypotension is assessed by measuring orthostatic or postural blood pressure and pulse changes. This procedure is done by assessing when the client moves from supine to sitting to standing, and sometimes from supine to standing. There are variations in how this procedure is done in terms of position changes as well as timing (Arnold & Raj, 2017; Fedorowski et al., 2022; Kim & Farrell, 2022; Wieling et al., 2022). For example, blood pressure and pulse can be assessed immediately following a position change to assess for initial orthostatic hypotension or at 3 minutes to assess for delayed orthostatic hypotension (Fedorowski et al., 2022). Because of the variations of assessment, you should document the approach (position changes) and the timing used. Here is a common way to proceed:

1. The client rests supine for five minutes.
2. Take blood pressure and pulse in the supine position.
3. The client stands up.
4. Take blood pressure and pulse immediately (within 30 seconds) and then again at 3 minutes.

NOTE: If the client is severely symptomatic, you may add a sitting position between supine and standing. Alternatively, some practitioners use only sitting to standing due to convenience in primary care. In addition, some clients may be referred for a **table test**.

How to Evaluate the Findings

Normal variation is a 10 mm Hg decrease in blood pressure (systolic) from lying to standing and an increase in pulse of 10–15 bpm.

A decrease in blood pressure from lying to standing of systolic ≥ 20 mm Hg or diastolic ≥ 10 mm Hg is identified as orthostatic hypotension. An increase in pulse from lying to standing of ≥ 20 bpm is identified as orthostatic tachycardia.



Technique Tips

The healthcare provider determines the maximum inflation pressure in the supine position and then uses this same number throughout all readings. Leave the blood pressure cuff on the whole time. If a client is unable to stand during the orthostatic blood pressure assessment, have them sit and dangle their legs. To ensure safety, have a safe place for the client to land/sit if dizzy.

6.6.7 Hypertension

Chronically elevated blood pressure (BP) is known clinically as hypertension. *Hypertension* is typically diagnosed as *BP that is greater than or equal to 130/80 mm Hg* in adults; it is important to note that this is a lower threshold than previously noted by Hypertension Canada (Goupil et al., 2025). Typically, hypertension treatment is focused on the systolic pressure and keeping it below 130 mm Hg (Goupil et al., 2025). Achieving this

target is usually sufficient because it results in low cardiovascular risk “even when diastolic BP is 70-90 mm Hg” (Beddhu et al., 2018 as cited in Goupil et al., 2025, p. E6).

Hypertension is typically a silent disorder, so hypertensive clients may not recognize the seriousness of their condition and not adhere to their treatment plan. The result is often a heart attack or stroke. Hypertension may also lead to an aneurysm (ballooning of a blood vessel caused by a weakening of the wall), peripheral arterial disease (obstruction of vessels in peripheral regions of the body), chronic kidney disease, or heart failure (OER#2).

Common errors in measurement and natural fluctuations in blood pressure can result in readings that erroneously suggest hypertension. Some of the errors are due to the operator (i.e., the healthcare provider) and others are due to client anxiety and situational determinants. As a healthcare provider, it is important to review your technique to assess possible measurement errors and assess the client for factors that could elevate blood pressure. If the client's blood pressure is elevated, repeat the measurement for accuracy, and then take the blood pressure in the opposite arm.

Because hypertension is a silent disorder, healthcare providers measure blood pressure at regular intervals. The intervals depend on the client's health status and risk factors. Before a diagnosis of hypertension is made, blood pressure is monitored over days, weeks, or months either in the office using an automatic blood pressure machine or at home using an ambulatory blood pressure machine.

Points of Consideration

It is important to note the distinction between elevated blood pressure and a diagnosis of hypertension. Elevated blood pressure refers to an isolated reading, whereby the client has an elevated finding. Hypertension refers to a clinical diagnosis whereby the client has met the criteria for chronically elevated blood pressure. Hypertension will precipitate a treatment protocol, whereas an elevated finding may just require monitoring.

Guidelines to Determine Hypertension in Adults

In this section, guidelines to determine hypertension in *primary care* are discussed since this is the setting where hypertension is most often diagnosed. Guidelines to determine hypertension are updated regularly, so it is important to check them regularly. In Canada, you can check out the Hypertension Canada website. It is best to assess and evaluate BP with a “*validated* automated device and using a *standardized* method” as described below (Goupil et al., 2025, pg. E2). However, validated devices are not always available, and in this case, manual BP is taken.

Hypertension Canada (Goupil et al., 2025) recommends that the client should not participate in exercise and consume caffeine and tobacco in at least 30 minutes prior to having their blood pressure taken. Since the client should be relaxed, they should empty their bladder and bowel (if needed). Additionally, it is preferable that they are not in any acute anxiety, stress, and pain.

As per Hypertension Canada, the following **techniques** should be adhered to when assessing BP in a primary care setting:

- The client should be placed in a quiet room with no noises/disturbances, and they should be asked to sit quietly – not moving or talking throughout the procedure.
 - They should be seated in a chair with legs uncrossed, feet flat on floor, relaxed with their back against the back of the chair.
 - The arm should be bare and rested on a table with their hand facing upwards.
 - It is best that they are at rest for 5 minutes prior to the measurements.
 - And then, BP should be measured with an automatic cuff three times “at 1-minute intervals” – all values should be recorded, and the values should be averaged.
- (Goupil et al., 2025).



Technique Tips

If one of the above conditions is not met, the blood pressure is still taken, but the healthcare provider must take it into consideration. If the blood pressure is elevated, it needs to be repeated to assess the possibility of hypertension. In addition, you should assess and document all medications (prescribed and over-the-counter), supplements, and legal and illegal substances that the client takes, as these can influence BP.

When hypertension is diagnosed in a primary setting, it is recommended (when feasible to do so) to conduct out-of-office (home BP monitoring) to confirm the diagnosis and rule out white-coat hypertension (a situation where BP is elevated in clinical settings) (Goupil et al., 2025). However, when out-of-office monitoring is not feasible, then repeated office measurements are recommended (Goupil et al., 2025).

Treatment approaches (lifestyle or pharmacotherapy) are tailored so that systolic BP is lowered to less than 130 mm Hg; although this target can vary for each client based on adverse effects (Goupil et al., 2025). Hypertension Canada (Goupil et al., 2025) recommends the following treatment approaches.

BP greater than or equal to 130/80, but less than 140/90:

- Lifestyle modification is recommended.
- Reassessment of BP in 3 to 6 months; if the BP remains in this range at the next assessment, then continue to reassess every 6 to 12 months.
- A series of tests is recommended to assess cardiovascular disease risk, such as blood tests (e.g., fasting **lipid panel**, **Hemoglobin A1c**, fasting blood glucose, creatinine) and **12-lead electrocardiography**.

BP greater than or equal to 140/90 (or 130-139 and at high cardiovascular disease risk, such as coronary artery disease, heart failure, kidney disease, diabetes, greater than or equal to 75 years of age):

- Lifestyle modification is recommended.
- Pharmacotherapy (medications) initiation.
- Reassess every 1 to 3 months “until BP at target” and then every 6 to 12 months.

However, it is important to recognize cues related to a *hypertensive crisis*, which is when a client's BP is greater

than 180/120 mm Hg (Sibley et al., 2020). A hypertensive crisis is a priority of care as it can result in cardiovascular events such as a myocardial infarction (heart attack) or a cerebrovascular accident (stroke). Associated cues may include angina (chest pain), shortness of breath, dizziness, confusion, and loss of consciousness. When a hypertensive crisis is suspected, the client should be referred to the hospital emergency department for immediate assessment and treatment.

Modifiable and Non-Modifiable Risk Factors

As part of the assessment, you should assess a client's cardiovascular risk factors for atherosclerosis and hypertension. These risk factors are categorized as modifiable and non-modifiable. See *Table 6.6.1* for an overview of risk factors adapted based on Hypertension Canada guidelines (Leung et al., for Hypertension Canada, 2017)

Table 6.6.1: Modifiable and Non-Modifiable Risk Factors

Non-modifiable	Modifiable
• Age 55 years or older • Male sex and postmenopausal female • Family history of cardiovascular disease that began in males younger than 55 years and in females younger than 65 years	• Smoking • Stress • Sedentary lifestyle (little or no physical activity) • Poor dietary habits (high sugar, high sodium, high fat, high cholesterol) • Abdominal obesity/overweight • Dysglycemia and dyslipidemia • Non-adherence to treatment plans (e.g., medication, diet, exercise regimen)



Activity: Test Your Knowledge

Please answer the three questions in the following question set.

Quiz Text Description

1. Blanks Activity

1. Chronically elevated blood pressure is known clinically as hypertension and is defined as chronic and persistent blood pressure measurements of ____ / ____ mm Hg or above in the adult.

2. MultiChoice Activity

2. Which hypertension factors are modifiable risk factors? Select all that apply.

- a. Male sex
- b. Alcohol intake
- c. Non-adherence to treatment plans (e.g., medication, diet, exercise regimen)
- d. Anxiety and stress
- e. Family history of cardiovascular disease
- f. Smoking
- g. Age of 55 years or older
- h. Sedentary lifestyle
- i. Postmenopausal females

3. MultiChoice Activity

3. Kanya has been diagnosed with hypertension and has a family history of cardiovascular disease. Education regarding the importance of adhering to the treatment plan is a significant role of a healthcare provider. Which outcomes can result when a client does not adhere to their treatment plan? Select all that apply.

- a. Fatigue
- b. Chronic kidney disease
- c. Heart attack
- d. Aneurysm
- e. Peripheral arterial disease
- f. Stroke
- g. Blurry vision

Solution:

1. Chronically elevated blood pressure is known clinically as hypertension and is defined as chronic and persistent blood pressure measurements of **130 / 80** mm Hg or above in the adult.
2. b. Alcohol intake; c. Non-adherence to treatment plans (e.g., medication, diet, exercise regimen); d.

- Anxiety and stress; f. Smoking; h. Sedentary lifestyle;
3. b. Chronic kidney disease; c. Heart attack; d. Aneurysm; e. Peripheral arterial disease; f. Stroke;

6.6.8 Health Promotion

As part of your role, it is important to discuss healthy behaviours to prevent hypertension and reduce high blood pressure. As per Hypertension Canada (Goupil et al., 2025), the following *healthy behaviours* are recommended:

- Moderate-intensity exercise such as walking, biking, jogging, or swimming for about 30 to 60 minutes per day for at least five days per week.
- If relevant, weight reduction aiming for a BMI range of 18.5 to 24.9 and a waist circumference of less than 88 cm for females and less than 102 cm for males.
- Diet with low sodium intake, high potassium intake, rich in vegetables, fruits, plant-source proteins (reducing saturated fat and cholesterol), whole grains, and low-fat dairy products.
- Abstaining from or reducing alcohol intake and abstaining from smoking.
- Stress management interventions.

These behaviours are important to maintaining an overall healthy lifestyle and maintaining healthy blood pressure levels. It is also important to consider health promotion as it relates to blood pressure from a relational and structural perspective. A *relational health promotion* approach emphasizes social change at the relational level, meaning the relationships between people, places, environments, spaces, beliefs, meanings, and events. A *structural health promotion* approach focuses on structural aspects of health and well-being. In other words, it addresses policies and practices that affect health at a broader community level, such as systemic discrimination. This approach to health promotion recognizes that *broader social structures* play an important role in health, and that one's participation and access within a community are shaped by one's social location. The goal is to dismantle the (often hidden) social processes that contribute to the maintenance of social exclusion and to actively promote health equity.

As such, you will want to discuss these healthy behaviours in the context of the client's daily life and, when needed, advocate on their behalf.

From Theory to Practice

Blood pressure measurement is important because it provides objective data about the client's health and illness state. Changes in blood pressure act as a cue for healthcare providers' diagnostic reasoning. Blood pressure fluctuates with internal and external factors. Therefore, it is important to take more than one measurement before making clinical decisions.

It is always important to ensure *correct techniques* when taking blood pressure.

In determining the relevance of the blood pressure reading, the healthcare provider considers the client's baseline blood pressure, previous readings, and health status. The blood pressure reading is always taken in conjunction with a pulse. Diagnostic reasoning takes into account blood pressure, pulse, and subjective and objective client data.

Now you have an opportunity to find the errors in measurement techniques. The first activity involves watching a short film clip. Check it out!

What errors in technique is this healthcare provider making while taking blood pressure?

Film Clip: "Blood Pressure – Multiple Errors" by Toronto Metropolitan University [1:21] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Text Description

This activity contains a set of dialogue cards, which are described below.

Activity Description or Instruction:

1. **What errors in technique is this healthcare provider making while taking blood pressure?**

Solution:

1. In the previous film clip, a number of measurement errors were made. It is important to ensure the following techniques:
 - Perform hand hygiene before and after.
 - Correct cuff placement must be determined by palpating the brachial artery.
 - Maximum pressure inflation must be determined before a blood pressure can be accurately taken.
 - The cuff is securely fastened around the arm so that only one finger can be placed between the cuff and the client's arm.
 - The cuff should not be moveable.
 - The stethoscope is cleansed before using.
 - The client should sit still with feet placed flat on the floor while having the blood pressure taken.



Activities: Test Your Understanding

Now that you have completed the BP content, it's time to test your knowledge. Try to answer the following questions (you may want to review parts of the chapter before answering).

Activity 1

Watch and listen to the Korotkoff sounds while blood pressure is taken in the audio clip. What are the systolic and diastolic blood pressures?

Video: "Blood Pressure – Korotkoff Sounds II" by Toronto Metropolitan University [0:56] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Audio clip: Korotkoff sounds

Text Description

____/____ mm Hg

Text Description

Answer.

Answer: 112/82 mm Hg

NOTE: You should aim to obtain a measurement within 2-4 mm Hg. In this testing environment, it may depend on the quality of your computer speakers. In actual practice, the stethoscope's quality is a main determinant of accuracy.

Activity 2

Watch and listen to the Korotkoff sounds while blood pressure is taken in the next audio clip. What are the systolic and diastolic blood pressures?

Video: "Blood Pressure – Korotkoff Sounds III" by Toronto Metropolitan University [0:56] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Audio clip: Korotkoff sounds

Text Description

____/____ mm Hg

Text Description

Answer.

Answer: 138/70 mm Hg

NOTE: You should aim to obtain a measurement within 2-4 mm Hg. In this testing environment, it may depend on the quality of your computer speakers. In actual practice, the stethoscope's quality is a main determinant of accuracy.

Activity 3

Which one of the two images below (Image A or Image B) demonstrates the correct way of putting the earpieces of the stethoscope in your ears?

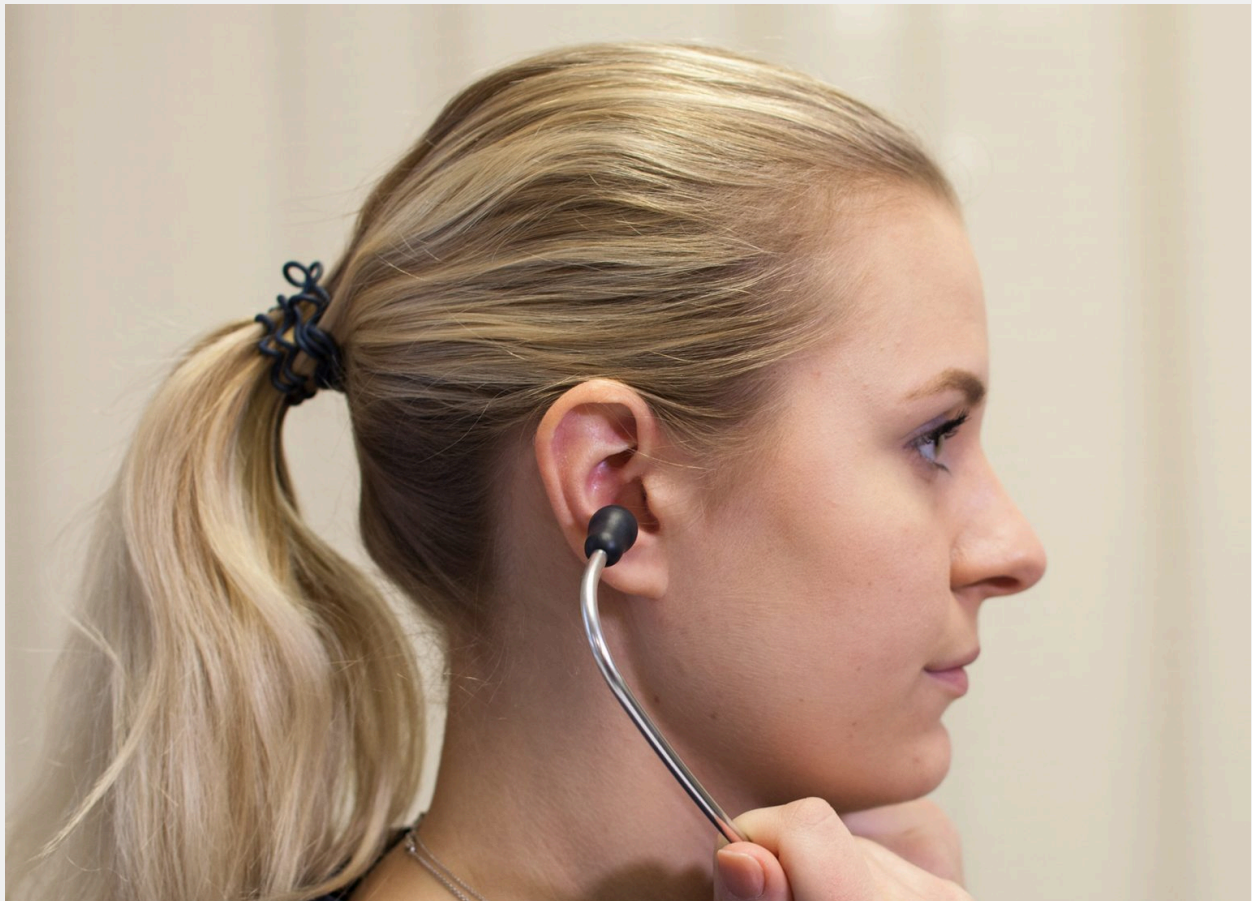


Image A



Image B

Text Description

This activity contains a set of dialogue cards, which are described below.

Activity Description or Instruction:

1. **Which one of the two images below (Image A or Image B) demonstrates the correct way of putting the earpieces of the stethoscope in your ears?**

Solution:

1. Image A is Correct! The stethoscope is in the ears the correct way! In Image B, the stethoscope is in the ears the incorrect way.
Rationale: The slope of the stethoscope's ear pieces is inserted at the same angle as the ear canal (i.e., pointing forward or pointing toward the nose). The action shown in Image B is incorrect, as the earpieces are pointed straight into the ears.

Text Description

The bell of the stethoscope is best used to hear Korotkoff sounds. (True/False)

Solution:

Correct answer: True

Text Description

Drag the words into the correct boxes.

In a blood pressure measurement of 110/70, the first number is the _____ and the second number is the _____.

Possible answers:

- systolic pressure
- diastolic pressure

Solution: In a blood pressure measurement of 110/70, the first number is the **systolic pressure** and the second number is the **diastolic pressure**.

Text Description

A healthy elastic artery _____.

- a. is a resistance artery.
- b. is compliant.
- c. has a thin wall and irregular lumen.
- d. reduces blood flow.

Solution:

Correct answer(s): b. is compliant.

Text Description

Which of the following symptoms may be a result of orthostatic hypotension?

- a. Fatigue
- b. Nocturia
- c. Chest pain
- d. Dizziness

Solution:

Correct answer(s): d. Dizziness

Text Description

The healthcare provider assesses an older client's blood pressure for the first time at a walk-in clinic. The healthcare provider obtains a reading of 164/84 mm Hg. What should the healthcare provider do first?

- a. Repeat the blood pressure on the other arm.
- b. Take the client's pulse.
- c. Inform the most responsible provider.
- d. Provide education to the client.

Solution:

Correct answer(s): a. Repeat the blood pressure on the other arm.

Text Description

A woman's pre-pregnancy pulse and blood pressure are 72 bpm and 112/78 mm Hg. Which findings are of most concern to the healthcare provider?

- a. Pulse 82 bpm and BP 108/70 mm Hg at the end of the first trimester.
- b. Pulse 90 bpm and BP 104/68 mm Hg at the beginning of the second trimester.
- c. Pulse 90 bpm and BP 138/88 mm Hg towards the latter half of the final trimester.
- d. Pulse 68 bpm and BP 118/82 mm Hg in the first half of the first trimester.

Solution:

Correct answer(s): c. Pulse 90 bpm and BP 138/88 mm Hg towards the latter half of the final trimester.

Text Description

Select the correct number to indicate the order in taking blood pressure.

- 1. ____ Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is no longer felt, and then continue to inflate 20–30 mm Hg more (maximum pressure inflation).
- 2. ____ Note the points at which you hear the first appearance of Korotkoff sound (systolic blood pressure), and the last Korotkoff sound before it goes silent (diastolic blood pressure).
- 3. ____ Deflate the cuff quickly.
- 4. ____ Deflate the cuff slowly and evenly at about 2 mm Hg per second.
- 5. ____ Inflate the cuff to the maximum pressure inflation number.
- 6. ____ Now, you can start blood pressure so place the bell of the cleansed stethoscope over the brachial artery using a light touch and complete seal.
- 7. ____ Open the valve slightly.

Possible answers:

- 2.
- 6.
- 4.
- 3.
- 7.
- 1.
- 5.

Solution:

1. **1.** Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is no longer felt, and then continue to inflate 20–30 mm Hg more (maximum pressure inflation).
2. **7.** Note the points at which you hear the first appearance of Korotkoff sound (systolic blood pressure), and the last Korotkoff sound before it goes silent (diastolic blood pressure).
3. **2.** Deflate the cuff quickly.
4. **6.** Deflate the cuff slowly and evenly at about 2 mm Hg per second.
5. **4.** Inflate the cuff to the maximum pressure inflation number.
6. **3.** Now, you can start blood pressure so place the bell of the cleansed stethoscope over the brachial artery using a light touch and complete seal.
7. **5.** Open the valve slightly.

Text Description

Select the correct number to indicate the order in taking blood pressure.

1. ____ Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is no longer felt, and then continue to inflate 20–30 mm Hg more (maximum pressure inflation).
2. ____ Note the points at which you hear the first appearance of Korotkoff sound (systolic blood pressure), and the last Korotkoff sound before it goes silent (diastolic blood pressure).
3. ____ Deflate the cuff quickly.
4. ____ Deflate the cuff slowly and evenly at about 2 mm Hg per second.
5. ____ Inflate the cuff to the maximum pressure inflation number.
6. ____ Now, you can start blood pressure so place the bell of the cleansed stethoscope over the brachial artery using a light touch and complete seal.
7. ____ Open the valve slightly.

Possible answers:

- 4.
- 1.
- 7.
- 3.
- 5.
- 2.
- 6.

Solution:

1. **1.** Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is no longer felt, and then continue to inflate 20–30 mm Hg more (maximum pressure inflation).
2. **7.** Note the points at which you hear the first appearance of Korotkoff sound (systolic blood pressure), and the last Korotkoff sound before it goes silent (diastolic blood pressure).
3. **2.** Deflate the cuff quickly.
4. **6.** Deflate the cuff slowly and evenly at about 2 mm Hg per second.
5. **4.** Inflate the cuff to the maximum pressure inflation number.
6. **3.** Now, you can start blood pressure, so place the bell of the cleansed stethoscope over the brachial artery using a light touch and complete seal.

7. **5.** Open the valve slightly.

Text Description

Select the correct number to indicate the order in taking blood pressure.

1. ____ Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is no longer felt, and then continue to inflate 20–30 mm Hg more.
2. ____ Deflate the cuff slowly and evenly at about 2 mm Hg per second.
3. ____ Note the points at which you hear the first appearance of Korotkoff sound (systolic blood pressure), and the last Korotkoff sound before it goes silent (diastolic blood pressure).
4. ____ Place the bell of the cleansed stethoscope over the brachial artery using a light touch, but with an airtight seal.
5. ____ Open the valve slightly.

Possible answers:

- 5.
- 1.
- 4.
- 2.
- 3.

Solution:

1. **1.** Palpate the radial or brachial artery, inflate the blood pressure cuff until the pulse is no longer felt, and then continue to inflate 20–30 mm Hg more.
2. **4.** Deflate the cuff slowly and evenly at about 2 mm Hg per second.
3. **5.** Note the points at which you hear the first appearance of Korotkoff sound (systolic blood pressure), and the last Korotkoff sound before it goes silent (diastolic blood pressure).
4. **2.** Place the bell of the cleansed stethoscope over the brachial artery using a light touch, but with an airtight seal.
5. **3.** Open the valve slightly.



Watch: Blood Pressure Practice Sounds with Answers

Video: “Blood Pressure Practice Sounds with Answers (Korotkoff Sounds) Nursing School Skills” by RegisteredNurseRN [3:29] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

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6.7 Temperature

Appendix Resource: Checklist

See Appendix D3: Checklist for Blood Pressure, which reviews the steps for obtaining a “Manual Blood Pressure.”

The human body’s core temperature (internal body temperature) is measured in degrees Celsius (°C) or Fahrenheit (°F). In Canada, degrees Celsius are most commonly used.

In adults, the *normal core body temperature* (referred to as normothermia or afebrile) is 36.5–37.5°C or 97.7–99.5°F.

A wider temperature range is acceptable in *infants and young children*, and can range from 35.5–37.7°C or 95.9–99.8°F. Infants and children have a wider temperature range because their heat control mechanisms are less effective. They are at risk for heat loss for many reasons, including having less subcutaneous fat than adults, a larger body surface area in comparison to weight (and larger head size in proportion to the rest of the body), immature metabolic mechanisms (e.g., they may be unable to shiver), and limited ability to produce heat through activity. They are also at risk of excessive heat production due to crying and restlessness, as well as external factors such as being wrapped in too many blankets.

Older adults tend to have lower body temperatures and are at risk for hypothermic states; reasons for this may include having less subcutaneous tissue acting as insulation, loss of peripheral vasoconstriction capacity, decreased cardiac output with resultant lowered blood flow to the extremities, decreased muscle mass resulting in reduced heat production capacity, and decreased metabolic responses.

Points of Consideration

It is important to monitor and regulate temperature in newborns and infants because of the temperature fluctuations that place them at higher risk for hypothermia and hyperthermia, whereas temperature changes in older adults are often minimal.

See *Table 6.7.1* for *normal temperature ranges* based on *method*. The normal ranges vary slightly for each of the methods. It is important to consider a client’s baseline temperature as some individuals present with a temperature slightly above or below these ranges. To make an informed clinical judgement, examine the client’s records to determine a trend in temperature. A pattern of high or low temperature findings may reveal a baseline for your client. As a healthcare provider, it is important to determine the significance of the temperature by also considering influencing factors and the client’s overall state of health.

Table 6.7.1: Normal Temperature Ranges

Method	Range
Oral	35.8–37.3°C
Axillary	34.8–36.3°C
Tympanic	36.1–37.9°C
Rectal	36.8–38.2°C

Other factors that influence temperature include diurnal rhythm, exercise, stress, menstrual cycle, and pregnancy. The diurnal cycle causes a fluctuation of 1°C, with temperatures lowest in the early morning and highest in the late afternoon. During exercise, body temperature rises because the body is using energy to power the muscles. Temperature can rise as a result of stress and anxiety, due to stimulation of the sympathetic nervous system and increased secretion of epinephrine and norepinephrine. Body temperature varies throughout a woman's menstrual cycle due to hormonal fluctuations, rising after ovulation until menstruation by about 0.5–1°C. Body temperature is slightly elevated during pregnancy as a result of increased metabolism and hormone production, such as progesterone.



Activity: Test Your Understanding

Text Description

Drag the condition to the correct description.

1. ____ refers to an elevated temperature.
2. ____ can occur from internal sources such as a fever caused by infection.
3. ____ refers to a lowered body temperature.
4. ____ can lead to cell damage.
5. ____ can occur from external sources such as exposure to cold for an extended period of time.
6. ____ can occur from external sources such as exposure to excessive heat on a hot day.
7. ____ can lead to loss of consciousness.

Possible answers:

- Hyperthermia
- Hypothermia
- Hyperthermia
- Hypothermia
- Hyperthermia
- Hyperthermia
- Hypothermia

Solution:

1. **Hyperthermia** refers to an elevated temperature.
2. **Hyperthermia** can occur from internal sources, such as a fever caused by infection.
3. **Hypothermia** refers to a lowered body temperature.
4. **Hyperthermia** can lead to cell damage.
5. **Hypothermia** can occur from external sources, such as exposure to cold for an extended period of time.
6. **Hyperthermia** can occur from external sources, such as exposure to excessive heat on a hot day.
7. **Hypothermia** can lead to loss of consciousness.

6.7.1 Methods of Temperature Measurement

Methods of measuring a client's body temperature vary based on developmental age, cognitive functioning, level of consciousness, state of health, safety, and agency/unit policy. The healthcare provider *chooses the best method* after considering client safety, accuracy, and least invasiveness, all contingent on the client's health and illness state. The most accurate way to measure core body temperature is an invasive method through a pulmonary artery catheter. This is only performed in a critical care area when constant measurements are required along with other life-saving interventions.

Methods of measurement include *oral*, *axillary*, *tympanic*, *rectal*, and *dermal routes*. It is best to engage in a discussion with the institution and the unit that you work in about what methods they use and why.

Tympanic routes are common in the adult population, both in primary settings and acute settings. This route should be avoided in a client who cannot hold their head still due to the risk of injury of the tympanic membrane.

Oral temperature can be taken with clients who can follow instructions, so this kind of measurement is common for clients over the age of four, or even younger children if they are cooperative. Usually, with a child who is stable or in a routine situation (and the client is able to follow instructions, about age four), then, most likely, you would do oral temperature. However, you would avoid an oral route with a confused client, as you need to assess whether they have recently consumed hot or cold fluids. In these cases, you may take a tympanic or axillary; these routes are also preferable when a client is on oxygen delivered via a face mask (a mask that covers the nose and mouth) because this can alter the temperature.

Also, for children younger than four who are stable and in a routine situation, *axillary temperature* is commonly measured unless a more accurate reading is required. If you have a concern about the temperature, a rectal temperature is preferred in children.

Rectal temperature is an accurate way to measure body temperature (Mazerolle, Ganio, Casa, Vingren, & Klau, 2011) and is particularly used in the pediatric population for accuracy and in acute situations. The rectal route is recommended by the Canadian Pediatric Society for children under two years of age (Leduc & Woods, 2017). However, rectal temperatures are commonly taken with children under three in several situations, such as when in a hospital, when in an isolette, and when the client is not stable or in acute situations. However, this method is not used on infants younger than thirty days or premature infants because of the risk of rectal tearing. If the rectal method is required, the procedure is generally only used by nurses and physicians.

Dermal routes are alternative methods of measurement that may be used in some agencies and practice areas. This method can involve holding the device and sliding it over the skin of the forehead and then down over the temporal artery in one motion. Dermal strips can also be placed on the forehead to measure skin temperature, but are not yet widely used, and the accuracy of this method has not yet been verified. More recently, there has been an increase in *non-contact infrared thermometers*, particularly in the era of COVID-19 and other highly transmissible diseases. Depending on the type, these thermometers can be held at a short distance from the forehead or temporal area to measure temperature. Alternatively, some handheld thermal scanners that use an infrared camera can be held at a greater distance to screen large masses of people. Please refer to the manufacturer's suggested reference range for non-contact infrared thermometers and thermal scanners.



Activity: Test Your Understanding

Video Description and Transcript

This interactive video is titled **Non-Contact Infrared Temperature**. It demonstrates the use of a non-contact infrared thermometer to measure a client's temperature.

Video description: The video shows how a non-contact infrared thermometer is used without touching the client's skin. The thermometer is held a short distance from the forehead or temporal area to obtain a temperature reading.

Transcript of interactive content:

- **Opening title:** Non-Contact Infrared Temperature
- **Fill in the missing words:** When taking a temperature using an infrared thermometer, hold it a **short** distance from the **forehead/temporal** or **temporal/forehead** area to measure temperature.
- **Image description:** A non-contact infrared thermometer is shown with the display screen visible.
- **On-screen text:** A temperature of **36.7 °C** is displayed on the screen.
- **Teaching note:** Non-contact infrared thermometers do not come into direct contact with the client's skin.
- **Teaching note:** This is within normal body temperature range according to this manufacturer's recommended reference range of **36.1 °C to 37.5 °C**.

Summary: The activity reinforces that a non-contact infrared thermometer is used by holding the device a short distance from the forehead or temporal area. The example reading shown is 36.7 °C, which is identified as within the manufacturer's recommended normal range for this device.

Points of Consideration

The accuracy of measurements is most often influenced by the healthcare provider's adherence to the correct technique.



Watch: On Temperature

Video: “How to Take a Temperature: Under Arm, Oral, Ear, Rectum, Skin, Temporal” by RegisteredNurseRN [7:09] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Video: “Vital Signs Machine” by InScope [2:24] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

6.7.2 Temperature Ranges

The human body’s core temperature (internal body temperature) is measured in degrees Celsius (°C) or Fahrenheit (°F). In Canada, degrees Celsius are most commonly used.

In adults, the *normal core body temperature* (referred to as normothermia or afebrile) is 36.5–37.5°C or 97.7–99.5°F.

A wider temperature range is acceptable in *infants and young children*, and can range from 35.5–37.7°C or 95.9–99.8°F. Infants and children have a wider temperature range because their heat control mechanisms are less effective. They are at risk for heat loss for many reasons, including having less subcutaneous fat than adults, a larger body surface area in comparison to weight (and larger head size in proportion to the rest of the body), immature metabolic mechanisms (e.g., they may be unable to shiver), and limited ability to produce heat through activity. They are also at risk of excessive heat production due to crying and restlessness, as well as external factors such as being wrapped in too many blankets.

Older adults tend to have lower body temperatures and are at risk for hypothermic states; reasons for this may include having less subcutaneous tissue acting as insulation, loss of peripheral vasoconstriction capacity, decreased cardiac output with resultant lowered blood flow to the extremities, decreased muscle mass resulting in reduced heat production capacity, and decreased metabolic responses.

Points of Consideration

It is important to monitor and regulate temperature in newborns and infants because of the temperature fluctuations that place them at higher risk for hypothermia and hyperthermia, whereas temperature changes in older adults are often minimal.

See *Table 6.7.2 for normal temperature ranges based on method*. The normal ranges vary slightly for each of the methods. It is important to consider a client’s baseline temperature as some individuals present with a temperature slightly above or below these ranges. To make an informed clinical judgement, examine the client’s records to determine a trend in temperature. A pattern of high or low temperature findings may reveal

a baseline for your client. As a healthcare provider, it is important to determine the significance of the temperature by also considering influencing factors and the client's overall state of health.

Table 6.7.2: Normal Temperature Ranges

Method	Range
Oral	35.8–37.3°C
Axillary	34.8–36.3°C
Tympanic	36.1–37.9°C
Rectal	36.8–38.2°C

Other factors that influence temperature include diurnal rhythm, exercise, stress, menstrual cycle, and pregnancy. The diurnal cycle causes a fluctuation of 1°C, with temperatures lowest in the early morning and highest in the late afternoon. During exercise, body temperature rises because the body is using energy to power the muscles. Temperature can rise as a result of stress and anxiety, due to stimulation of the sympathetic nervous system and increased secretion of epinephrine and norepinephrine. Body temperature varies throughout a woman's menstrual cycle due to hormonal fluctuations, rising after ovulation until menstruation by about 0.5–1°C. Body temperature is slightly elevated during pregnancy as a result of increased metabolism and hormone production, such as progesterone.



Activity: Test Your Understanding

Text Description

What influence does the following have on oral temperature readings? Drag the correct word 'higher temperature' or 'lower temperature' beside each item.

1. Coffee ____
2. Pregnancy ____
3. Morning ____
4. Ice cream ____
5. Exercise ____
6. Stress ____
7. Older Adult ____
8. After Ovulation ____

Possible answers:

- lower temperature
- higher temperature
- higher temperature
- higher temperature
- higher temperature
- lower temperature
- lower temperature
- higher temperature

Solution:

1. Coffee **higher temperature**
2. Pregnancy **higher temperature**
3. Morning **lower temperature**
4. Ice cream **lower temperature**
5. Exercise **higher temperature**
6. Stress **higher temperature**
7. Older Adult **lower temperature**
8. After Ovulation **higher temperature**

6.7.3 Oral Temperature

The normal oral temperature is 35.8–37.3°C (or 96.4–99.1°F). Oral temperature measurement is common and reliable because it is close to the sublingual artery. An oral thermometer is shown in *Figure 6.7.1*. The device has **blue colouring**, indicating that it is an oral or axillary thermometer as opposed to a rectal thermometer, which has red colouring.



Figure 6.7.1: Oral Thermometer

Technique

Remove the probe from the device and place a probe cover (from the box) on the oral thermometer without touching the probe cover with your hands. Place the thermometer in the client's mouth under the tongue and instruct the client to keep the mouth closed and not to bite on the thermometer. Ensure the thermometer probe is in the posterior sublingual pocket under the tongue, slightly off-centre. Leave the thermometer in place for as long as is indicated by the device manufacturer. The thermometer will beep within a few seconds when the temperature has been taken: most oral thermometers are electronic and provide a digital display of the reading. Discard the probe cover in the garbage (without touching the cover) and place the probe back into the device. See *Figure 6.7.2*: of an oral temperature being taken.



Figure 6.7.2: Oral temperature being taken



Technique Tips

Putting the probe cover on takes practice. You need to ensure that it snaps onto the probe. Sometimes the device will turn off after you take the probe out of the device if you take too long to put the probe cover on or insert it in the client's mouth. If so, discard the probe cover and re-insert the probe into the device to reset it. Then try again.

What Should the Healthcare Provider Consider?

Healthcare providers often measure the oral temperature, particularly when the client is conscious and can follow directions. Measurement of the oral temperature is not recommended for individuals who are unconscious, unresponsive, confused, have an endotracheal tube secured in the mouth, or cannot follow instructions.

Certain factors render the oral route less accurate, with the potential for falsely high or falsely low findings. If

the client has recently consumed hot or cold food or beverage, chewing gum, or has smoked prior to measurement, the healthcare provider should use another route, such as tympanic or axillary. Selecting an alternate route under the aforementioned circumstances is most conducive to a fast-paced clinical environment and most respectful of the client's time. If another route is not available, healthcare providers should wait 15 to 25 minutes to take the oral temperature following consumption of a hot or cold beverage/food. The temperature of the beverage/food also factors into the wait period, as extreme heat or cold will require longer wait times for oral temperature assessment. Healthcare providers should wait about 5 minutes if the client is chewing gum or has just smoked, since both of these activities can increase temperature.

Watch this next short film clip 6.7.1 and see how oral temperature is taken correctly. After watching the clip, try the technique yourself.



Watch: Oral Temperature Taken Correctly

Film Clip 6.7.1: "Oral Temperature – Taken Correctly" by Toronto Metropolitan University [0:57] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activity: Test Your Understanding

Quiz Text Description

1. MultiChoice Activity

Where in the mouth do you place the covered probe of the oral thermometer?

- a. left buccal mucosa
- b. posterior sublingual pocket
- c. left posterior pharyngeal wall

2. Blanks Activity

When placing the oral temperature probe under the tongue it should be ____ center.

3. MultiChoice Activity

Before placing the probe in the client's mouth, the client starts talking. Before long, the device turns off. How do you proceed to take the oral temperature?

- a. Place the covered probe in the client's mouth.
- b. Discard the probe cover and re-insert the probe into the device to reset it.
- c. Remove the probe cover and replace it with a new probe cover.

Solution:

1. b. posterior sublingual pocket
2. When placing the oral temperature probe under the tongue, it should be **slightly off/off** center.
3. b. Discard the probe cover and re-insert the probe into the device to reset it.

6.7.4 Tympanic Temperature

The normal tympanic temperature is usually 0.3–0.6°C higher than an oral temperature (OER #1). It is accurate because the tympanic membrane shares the same vascular artery that perfuses the hypothalamus. A tympanic thermometer is shown in *Figure 6.7.3*.



Figure 6.7.3: Tympanic thermometer

Technique

Remove the tympanic thermometer from the casing and place a probe cover (from the box) on the thermometer tip without touching the probe cover with your hands. Only touch the edge of the probe cover (if needed), to maintain clean technique. Turn the device on. Ask the client to keep their head still. For an adult or older child, gently pull the helix up and back to visualize the ear canal. For an infant or younger child (under 3), gently pull the lobe down. The probe is inserted just inside the opening of the ear. Never force the thermometer into the ear, and do not occlude the ear canal. Only the tip of the probe is inserted in the opening – this is important to prevent damage to the ear canal. Activate the device; it will beep within a few seconds to signal it is done. Discard the probe cover in the garbage (without touching the cover) and place the device back into the holder. See *Figure 6.7.4* of a tympanic temperature being taken.



Figure 6.7.4: Tympanic temperature being taken



Technique Tips

The technique of pulling the helix up and back (adult) or the lobe down (child under 3) is used to straighten the ear canal so the light can reflect on the tympanic membrane. If this is not correctly done, the reading may not be accurate. The probe tip is gently inserted into the opening to prevent damage to the ear canal. The ear canal is a sensitive and highly innervated part of the body, so it is important not to force the tympanic probe into the ear.

What Should the Healthcare Provider Consider?

The tympanic temperature method is a quick and minimally invasive way to take temperature. Although research has proven the accuracy of this method, some pediatric institutions prefer the accuracy of the rectal

temperature. The Canadian Pediatric Society found equal evidence for and against the use of the tympanic temperature route (Leduc & Woods, 2017). It concluded that tympanic temperature is one option for use with children, but suggested using rectal temperature for children younger than two, particularly when accuracy is vital. The tympanic temperature is not measured when a client has a suspected ear infection. It is important to check your agency policy regarding tympanic temperature.

Watch this next short *Film Clip 6.7.2* and see how tympanic temperature is taken correctly. After watching the clip, try the technique yourself. You can watch the clip and practice as many times as you like.



Watch: Tympanic Temperature Taken Correctly

Film Clip 6.7.2: “Tympanic Temperature – Taken Correctly” by Toronto Metropolitan University [1:00] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*



Activity: Test Your Understanding

Text Description

Drag the words into the correct boxes

1. When performing a tympanic temperature on a client over 3 _____ to visualize the ear canal. Then, if clear, insert the probe.
2. When performing a tympanic temperature on a client under 3 _____ to visualize the ear canal. Then, if clear, insert the probe.

Possible answers:

- pull the lobe down
- gently pull the helix up and back

6.7.5 Axillary Temperature

The normal axillary temperature may be as much as 1°C lower than the oral temperature. An axillary thermometer is the same electronic device as an oral thermometer, and both have a *blue end*.

Technique

Remove the probe from the device and place a probe cover (from the box) on the thermometer without

touching the cover with your hands. Ask the client to raise their arm away from their body. Place the thermometer in the client's armpit, on bare skin, as high up into the axilla as possible, with the point facing behind the client. Ask the client to lower their arm and leave the device in place for as long as is indicated by the device manufacturer. Usually, the device beeps in 10–20 seconds. Discard the probe cover in the garbage (without touching the cover) and place the probe back into the device. See *Figure 6.7.5* of an axillary temperature being taken.



Figure 6.7.5: Axillary temperature being taken.

What Should the Healthcare Provider Consider?

The axillary route is a minimally invasive way to measure temperature. It is commonly used in children. It is important to ensure that the thermometer is as high up in the axilla as possible with full skin contact and that the client's arm is then lowered down.

Watch this next short *film clip 6.7.3* and see how axilla temperature is taken correctly. After watching the clip, try the technique yourself. You can watch the clip and practice as many times as you like.



Watch: Axilla Temperature Taken Correctly

Film clip 6.7.3: “Axilla Temperature – Taken Correctly” by Toronto Metropolitan University [1:01] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

6.7.6 Rectal Temperature

The normal rectal temperature is usually 1°C higher than oral temperature (OER #1). A rectal thermometer has a **red end** to distinguish it from an oral/axillary thermometer. A rectal thermometer is shown in *Figure 6.7.6*.



Figure 6.7.6: Rectal thermometer

Technique

First, ensure the client's privacy. Wash your hands and put on gloves. For infants, lie them down in a supine position and raise their legs up toward the chest. You can encourage a parent to hold the infant to decrease movement and provide a sense of safety. With older children and adults, assist them into a side-lying position. Remove the probe from the device and place a probe cover (from the box) on the thermometer. Lubricate the

cover with a water-based lubricant, and then *gently insert the probe 2–3 cm inside the rectal opening of an adult, or less, depending on the size of the client*. In pediatrics, devices usually have a mark on the probe which indicates how deep to insert the probe. The device beeps when it is done.

What Should the Healthcare Provider Consider?

Measuring rectal temperature is an invasive method. Some suggest its use only when other methods are not available, while others suggest that the rectal route is a gold standard in the infant population because of its accuracy, particularly in acute situations when the client is unstable. The Canadian Pediatric Society (Leduc & Woods, 2017) has referred to research indicating that rectal temperatures may remain elevated after a client's core temperature has started to return to normal, but after reviewing all available evidence, it still recommends measuring rectal temperature for children under the age of two, particularly when accuracy is vital.

Rectal temperature is not measured in infants under one month of age or premature newborns. Other contraindications include: a client with a bleeding disorder, a rectal abnormality, or post-rectal surgery.



Activity: Test Your Understanding

Quiz Text Description

1. TrueFalse Activity

Unlike other temperature measurements, a rectal thermometer probe has a red end. (True/False)

2. MultiChoice Activity

What are important procedural considerations when performing a rectal temperature on an infant. Select all that apply.

- a. Ask parent or caregiver to leave the room
- b. Wash you hands and put on gloves.
- c. Lie the infant down in a supine position with legs raised up toward chest.
- d. Ask parent or caregiver to support infant in a side lying position.
- e. Lubricate the probe cover with water-based lubricant prior to insertion.

3. TrueFalse Activity

Normal rectal temperature is usually 1°C higher than oral temperature. (True/False)

4. Blanks Activity

Normal ranges are listed below without the method of measurement. Fill in the blanks with the correct reference range for rectal temperature.

35.8-37.3°C

34.8-36.3°C

36.1-37.9°C

36.8-38.2°C

The normal range for rectal temperature is ____ °C to ____ °C.

From Theory to Practice

Temperature is an important vital sign because it provides current data about the client's health and illness state. Changes in body temperature act as a cue for healthcare providers' diagnostic reasoning.

There are many ways to measure temperature. In determining the best method, the healthcare provider considers agency policy, the client's age, health and illness state, and the reason for taking the temperature. Healthcare providers must use the correct technique when measuring temperature, because this can influence client data.

When determining the relevance of the temperature, the healthcare provider considers the client's baseline data and the situation. Diagnostic reasoning about temperature always involves considering additional data, including other vital sign measurements and subjective and objective client data.



Activities: Test Your Understanding

Activity 1

Which is the correct technique for measuring the tympanic temperature?

Image Description

The H5P image juxtaposition compares two images showing tympanic temperature technique. Learners can move the slider to compare Image A and Image B.

- **Image A:** A tympanic thermometer is placed in the patient's ear, but the ear is not being pulled up and back. This may affect the proper positioning of the thermometer probe.
- **Image B:** The patient's ear is gently pulled up and back while the tympanic thermometer is inserted. This demonstrates correct positioning for taking a tympanic temperature in an adult.

The comparison helps learners recognize the importance of positioning the ear correctly when using a tympanic thermometer.

Text Description

The correct technique for measuring tympanic temperature is Image ____.

Solution:

The correct technique for measuring tympanic temperature is Image **B**.

Text Description

This activity contains a set of dialogue cards, which are described below.

Activity Description or Instruction:

1. Which image is correct?
 - Answer: As per Image A, an incorrect technique is being demonstrated because there is no adjustment to the ear. The correct technique, as illustrated in Image B, is to gently pull the helix up and back while stabilizing the client's head with your hand for an adult/older child.

Text Description

What is the most accurate way to take the temperature of a one-year-old client?

- a. Oral Temperature
- b. Rectal Temperature
- c. Tympanic Temperature
- d. Axillae Temperature

Solution:

Correct answer(s): b. Rectal Temperature

Text Description

An adult client is drinking coffee. How should the healthcare provider measure the client's temperature? Select all that apply.

- a. Take the client's axillary temperature right away
- b. Take the client's oral temperature right away
- c. Take the client's tympanic temperature right away
- d. Wait two minutes and take the client's oral temperature
- e. Take the client's rectal temperature in five minutes

Text Description

What is the best way to measure temperature in a client who is confused? Select all that apply.

- a. Axillary temperature
- b. Temporal artery temperature
- c. Rectal temperature
- d. Oral temperature
- e. Tympanic temperature

Text Description

An infant's tympanic temperature is 37.7°C. How should the healthcare provider respond?

- a. Recognize this as normal
- b. Take a rectal temperature
- c. Apply a cold compress
- d. Re-take in the other ear

Text Description

How should the healthcare provider take the temperature of an adult client who is post-operation, day two following oral surgery?

- a. Avoid measuring temperature
- b. Take oral temperature every four hours
- c. Take tympanic temperature as needed
- d. Take rectal temperature once a shift

Activity 2

List the steps below in the correct order for each of the following techniques.

Oral Temperature Technique

Text Description

Select the correct number to list the steps in order

1. ____ Discard the probe cover in the garbage (without touching the cover)
2. ____ Place the thermometer in the mouth under the tongue in the posterior sublingual pocket (slightly off-centre) and instruct the client to keep mouth closed and not to bite on the thermometer
3. ____ Place the probe back into the device
4. ____ Remove the thermometer when the device beeps
5. ____ Remove the probe from the device and place a probe cover (from the box) on the oral thermometer without touching the cover with your hands
6. ____ Note the temperature on the digital display of the device

Possible answers:

- 2.
- 4.
- 5.
- 3.
- 1.
- 6.

Tympanic Temperature Technique

Text Description

Select the correct number to list the steps in order

1. ____ Activate the device
2. ____ Remove the tympanic thermometer from the casing and place a probe cover (from the box) on the thermometer tip without touching the cover with your hands
3. ____ Discard the probe cover in the garbage (without touching the cover) and place the device back into the holder
4. ____ For an adult or older child, gently pull the helix up and back to visualize the ear canal. For an infant or younger child (under 3), gently pull the lobe down

5. ____ Gently insert the probe into the opening of the ear
6. ____ Note the temperature on the digital display of the device

Possible answers:

- 4.
- 3.
- 1.
- 2.
- 5.
- 6.

Axillary Temperature Technique

Text Description

Select the correct number to list the steps in order

1. ____ Place the thermometer in the client's armpit as high up as possible into the axillae on bare skin, with the point facing behind the client, and ask the client to lower arm
2. ____ Remove the probe from the device and place a probe cover (from the box) on the thermometer without touching the cover with your hands
3. ____ Ask the client to raise the arm away from his/her body
4. ____ Discard the probe cover in the garbage (without touching the cover) and place the probe back into the device
5. ____ Note the temperature on the digital display of the device

Possible answers:

- 5.
- 2.
- 4.
- 1.
- 3.

Rectal Temperature Technique

Text Description

Select the correct number to list the steps in order

1. ____ Discard the probe cover in the garbage (without touching the cover) and place the probe back into the device
2. ____ Position the client appropriately
3. ____ Ensure the client's privacy and wash your hands and put on gloves
4. ____ Remove the probe from the device and place a probe cover on it
5. ____ Remove your gloves and wash your hands
6. ____ Lubricate the cover with a water-based lubricant

7. ____ Note the temperature on the digital display of the device when it beeps
8. ____ Gently insert the probe 2–3 cm inside the rectal opening of an adult, or less depending on the size of the client

Possible answers:

- 6.
- 4.
- 7.
- 8.
- 5.
- 2.
- 1.
- 3.

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6.8 Critical Thinking and Reflection Exercises

Case Study 1

Patient Profile

A 67-year-old patient was admitted for a routine knee replacement. Generally healthy but appears anxious and is gripping the bed rails tightly.

The Scenario

The student nurse enters the room running 15 minutes behind schedule. Seeking to catch up, the student quickly wraps a standard adult blood pressure cuff over the patient's thick winter sweater. While the electronic machine inflates, the student checks the time on a smartphone, silently counts the patient's respirations for 15 seconds, and multiplies by 4.

The machine flashes a blood pressure reading of 152/94 mmHg. The student records a respiratory rate of 24 breaths per minute and leaves the room without speaking to the patient.

Consider the following:

- What specific technical mistakes did the student make while taking these vital signs?
- How did the student's rushed behaviour and lack of communication likely affect the patient's physiological readings?
- What should a nurse do immediately if an electronic machine yields an unusually high blood pressure reading on an anxious patient?

Case Study 2

Patient Profile

A 24-year-old patient was admitted 6 hours ago for observation following an uncomplicated appendectomy.

The Scenario

At 08:00, the patient's vital signs are BP 120/80, Pulse 72, Temp 36.8°C, Resp 14. At 12:00, a student nurse checks the patient and notes the following values:

- **Blood Pressure:** 102/64 mmHg
- **Heart Rate:** 98 beats per minute (radial, weak)
- **Respirations:** 20 breaths per minute
- **Skin:** Cool to the touch and slightly damp

The patient states, "I feel a bit dizzy and tired... I guess I just need to sleep off the anesthesia". The student tells the patient to get some rest, documents the findings, and plans to recheck the patient at 1600, following the care plan orders to check VS q4h (vital signs every 4 hours)

Consider the following:

- Are the vital signs findings within the expected "acceptable" ranges? what do you think regarding the overall trend? How do the noon values compare to the 0800 values?
- What potential post-operative complication could cause a drop in blood pressure with a rising heart rate, cool skin, and dizziness?

Case Study 3

Patient Profile

A 54-year-old patient admitted to the medical floor with severe pneumonia. No other history of respiratory illnesses. Receiving oxygen via nasal prongs at 2L/min.

The Scenario

The student nurse walks in to perform a routine shift assessment. The patient is sitting upright, breathing heavily, and using their neck muscles to help pull air into their lungs. The student obtains the following vital signs:

- **Temperature:** 38.9°C (Oral)
- **Pulse:** 112 beats per minute
- **Respirations:** 28 breaths per minute
- **Oxygen Saturation (SpO₂):** 87% on 2L of oxygen

The patient is sweating profusely and can only speak in two-word sentences before stopping to catch their breath.

Consider the following:

- Are the vital signs as expected? Which vital sign(s) is/are remarkable? Which vital sign parameter is the most critical “red flag” at the moment and why?
- What must the student nurse do right away and why?
- How should the student nurse report the situation to update the team (primary nurse and/or physician) about the patient’s status?
- Using the **ISBAR** framework, organize your report about the patient:
 - **I** (Introduction): Who are you and who is the patient?
 - **S** (Situation): What is the immediate crisis?
 - **B** (Background): What is the clinical context?
 - **A** (Assessment): What are the current vital signs?
 - **R** (Recommendation): What do you need the team (nurse or doctor) to do right now?



Virtual Sphygmomanometer Blood Pressure Drill

The *virtual sphygmomanometer blood pressure drill* has 8 cases, and the objective is simple: obtain accurate blood pressure readings from the virtual sphygmomanometer.

Start by clicking the video play button.

6.9 Chapter Summary



Key Takeaways

Vital signs measure the body's basic functions. They are important because they can provide clues about underlying conditions that affect a person's health or show progress toward recovery. There are many methods for taking vital signs, but using the correct technique is essential for obtaining accurate measurements.

Normal vital signs measurements depend on a person's age, sex, and overall health, but they have very little meaning on their own. Nurses must interpret vital signs findings and integrate them with the subjective and other objective data collected from patient assessments. A holistic health assessment helps the nurse determine if the vital sign measurements are within normal limits for the individual patient.

It is essential that nurses establish a TNCR to understand the patient's lived experience and any additional information that can provide insight into their body, which may influence the technique and location for measuring vital signs and the significance of the findings. It is also important to communicate findings using language that patients can understand. Nurses can share vital signs information while providing health promotion teaching to patients.

After obtaining a patient's vital signs, it is important to analyze the results immediately, recognize deviations from expected normal ranges, and report findings appropriately. A nursing student must notify their instructor and/or the collaborating nurse caring for the patient of any vital sign measurement outside the patient's normal or expected range as soon as possible.

Reporting vital signs findings to the patient and health care team is as important as promptly documenting them, in accordance with professional, ethical, legal, and organizational nursing responsibilities.



Knowledge Check

- Video: Vital Signs Nursing: Respiratory Rate, Pulse, Blood Pressure, Temperature, Pain, Oxygen
- Case Study: Older Adult Client
- Case Study: Adult Client
- Case Study: Adolescent Client
- Case Study: Pediatric Client



For Further Reflection

It is important to document vital signs in a timely manner. Abnormal and unexpected findings must be reported promptly, so appropriate interventions can be put in place. As a student nurse, what will you do to ensure accurate vital signs measurement, interpretation, documentation, and reporting?

Appendix Resource: Checklist

See Appendix D1: Vital Signs Checklist, which outlines the steps to take when checking vital signs.

What would you do and say as the nurse?



Patient with ALS: Case Study Analysis

Review the scenario

Key Points

- Establish a TNCR with the patient by introducing yourself and designation. Explain to them that with their consent, you will be taking their vital signs (heart rate, blood pressure, respirations, temperature, and oxygen saturation) and doing a physical assessment before they are seen by the physician. You will also ask them some questions about how they are doing in general to assess their level of wellness and answer any questions they may have. Once you are finished, you will let the doctor know your findings
- Conduct a holistic health interview to get to know your patient. Find out what has happened and how/when they got diagnosed with ALS, including other past and current history, surgeries, as well as family history. Ask about medications and allergies. If possible, ask to see the medication bottles to check that medications are being taken correctly and if there are any questions
- Inquire about pain or discomfort, muscle cramping, weakness, and any difficulties with speech and swallowing
- Assess nutritional status, including diet preferences and general health status of the mouth (mucosa, teeth, taste and gag reflex [vagus-cranial nerve x]), as well as any recent weight gain or loss
- Ask about elimination patterns and assess if there are any challenges with hygiene and mobility in general. Assess if there are any issues related to safety, mobility, and activities of daily living (ADLs)
- Inquire about available support systems for the patient and spouse. Assess how the couple is doing with their new life as a married couple, including their ability to socialize with friends and family
- Check that there are no concerns regarding health care bills or any other pressing issues in general
- Assess the patient and their spouse's general knowledge about ALS and the disease progression. Inquire about what has been communicated by the neurologist. Once you determine if there is a specific knowledge deficit about the disease, you can teach and share information as needed. You can help the patient and their spouse obtain accurate information from appropriate sources

and refer them to the necessary health care team members, such as social work. You can suggest a referral to speech therapy to check their swallowing, get guidance regarding nutritional needs, and ensure they are safe by preventing aspiration and choking

- Following the health interview and subjective data collection, the patient will feel more comfortable with you and less anxious after you establish a TNCR. You can take the vital signs, being careful of any involuntary muscle movement, twitching, and weakness. Ensure the patient is comfortable, warm, and has the necessary privacy to feel at ease.
- Sanitize your hands and the equipment before using it on the patient. Inquire if the patient has eaten or drank anything that is very hot or very cold. Ask if they know their last numbers for the vital signs, and compare to any past records you may have
- Explain what you are doing and discuss the findings, avoiding unnecessary medical jargon. You can mention numbers and, based on previous records, state that the numbers are as expected for the patient or that they fall within the expected ranges. If there are any unexpected (abnormal) findings, proceed to do the physical assessment, ask the patient how they are doing, and report your findings to the physician as soon as possible. Explain to the patient that the findings are different from previous records, you will assess them further and contact the physician right away. Be careful about your nonverbal and verbal communication so as not to make the patient feel distressed
- Ensure the patient is safe, comfortable, and in no distress before you report and document your findings. If the patient is unstable, assess ABCs, intervene accordingly, then report and document the nursing care provided as soon as possible
- Provide reassurance to the patient about their vital signs and educate them regarding what the numbers measure and how they may vary in people depending on many factors. Check any knowledge deficits and suggest they monitor them at home and record them to keep track of their wellbeing if they are interested in doing so. The social worker can discuss resources for acquiring vital signs equipment to keep at home
- Depending on the stage of the disease, patient needs, and general wellbeing, you can recommend to the physician and patient a referral to the palliative care team so the community nurses can also help to monitor the patient at home

CHAPTER 7: INFECTION PREVENTION AND CONTROL

Chapter Overview



- 7.0 Learning Objectives
- 7.1 Chapter Introduction
- 7.2 Preventing Infection
- 7.3 Standard Precautions
- 7.4 Additional (Transmission-Based) Precautions
- 7.5 Personal Protective Equipment (PPE)
- 7.6 Infection Prevention and Control Practices
- 7.7 Other Hygienic Client Care Interventions
- 7.8 Surgical Asepsis and the Principles of Sterile Technique
- 7.9 Chapter Summary

7.0 Learning Objectives



Learning Objectives

By the end of this chapter, learners should be able to:

1. Demonstrate appropriate hand hygiene when providing patient care.
2. Review additional precautions and examine appropriate nursing interventions to implement them.
3. Practice the correct use of PPE.
4. Discuss general nursing interventions to prevent and control infection when providing nursing care.
5. Examine the importance of surgical asepsis and discuss ways to ensure sterile technique.

7.1 Chapter Introduction

Ensuring the use of safe, effective, and ethical infection prevention and control measures is an important component of nursing care. Nurses are responsible for knowing and applying relevant CNO standards, legislation, best practices, and organizational policies related to infection prevention and control. Public Health Ontario (PHO) also provides many resources to assist health care professionals in ensuring patients are protected from infection-related illnesses. When nurses and health care professionals follow infection prevention and control guidelines, they ensure the health and well-being of patients, staff, and everyone involved in patient care (CNO, 2026).



What would you do and say as the nurse?

You are a home-visiting nurse who has a patient with an abdominal open drain wound following surgery. The patient is 30 years old, and they are also dealing with uncontrolled diabetes, heart problems, and obesity. The patient had surgery 2 weeks ago and developed an infection, so they have been referred to your nursing team.

As the nurse in the following scenario, how would you demonstrate appropriate infection prevention and control?

7.2 Preventing Infection

Nurses are expected to recognize the signs of infection and educate patients about their treatment. More importantly, nurses have a critical role in preventing the spread of infection. A cyclic process known as the chain of infection describes the transmission of an infection. The spread of infection can be stopped by all health care professionals, including nurses, by implementing interventions to break one or more links in the chain of infection.

Chain of Transmission

The chain of transmission, also known as the chain of infection, describes the process of infection. There are six links in the chain:

1. Infectious Agent
2. Reservoirs
3. Portal of Exit
4. Modes of Transmission
5. Portals of Entry
6. Susceptible Host

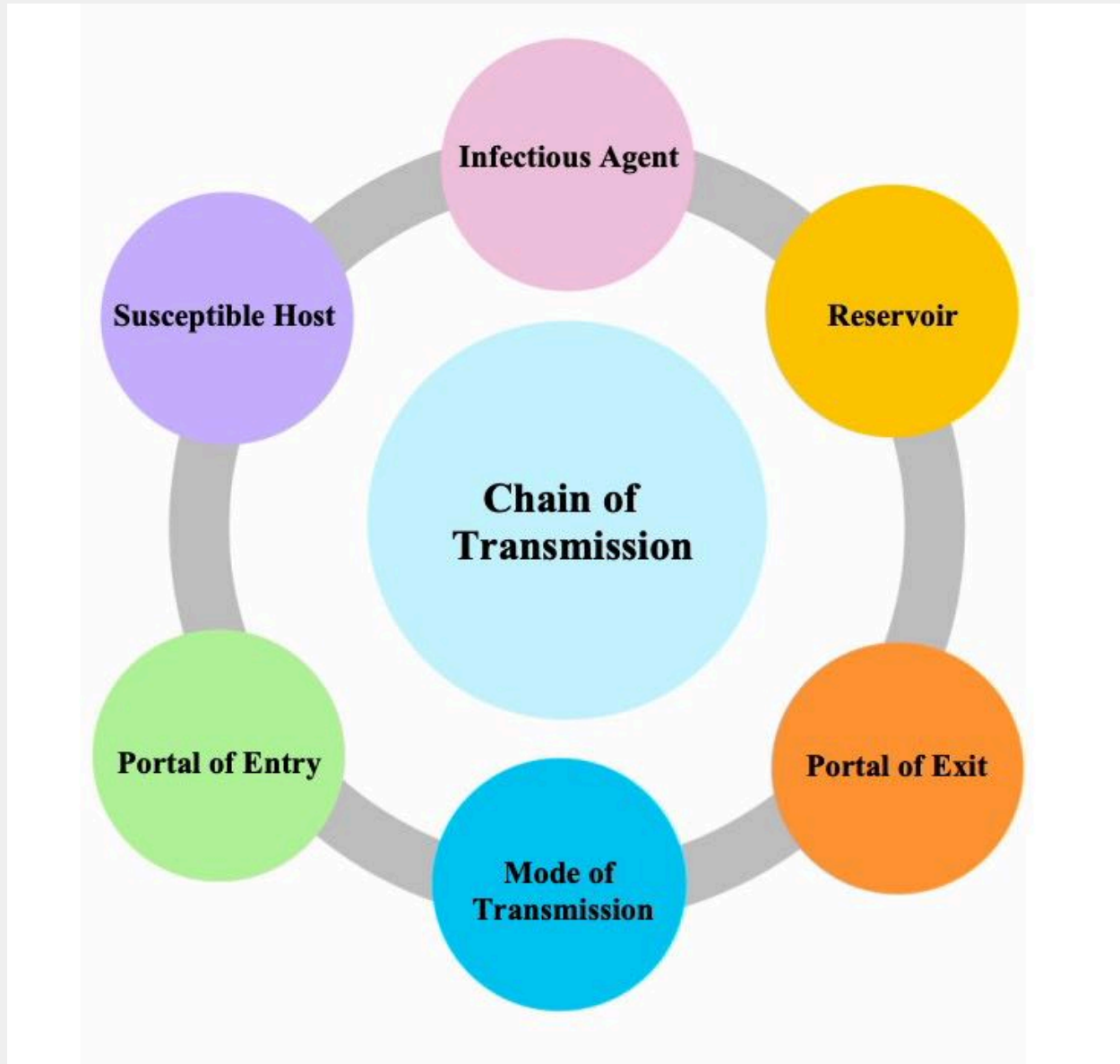
(PIDAC, 2012)

You need to understand how an infectious agent travels throughout the cycle to determine how to break the chain and prevent the transmission of the infectious disease. If a part of the chain of transmission is broken, the infection will not occur. Routine practices and additional precautions are used to break or minimize the chain of transmission.

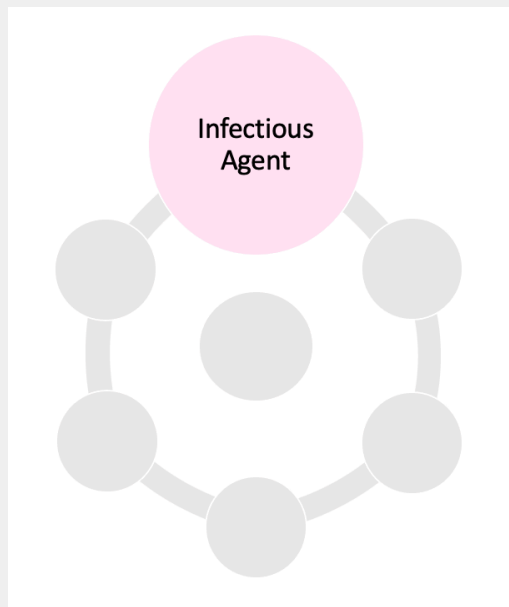


Activity: Test Your Understanding

Modes of Transmission



Click on the dropdown button under each chain of transmission link to learn more about that link in the chain and how to break the chain to stop or reduce the transmission of the infection



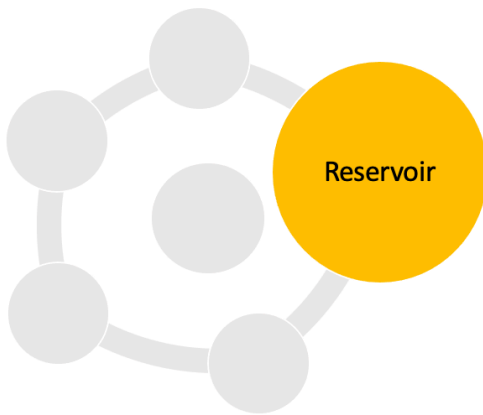
Infectious Agent

An infectious agent, also called a pathogen, is an organism or substance that can cause disease in a host. Infectious agents include bacteria, viruses, fungi, parasites, and prions. Examples include streptococcus and salmonella bacteria, influenza and chickenpox viruses, athlete's foot and oral thrush caused by fungi, malaria and giardia caused by parasites, and Creutzfeldt–Jakob disease caused by prions.

Pathogens may live within a host or remain dormant outside a living host until they enter the body. They can adapt to biological, behavioural, and environmental conditions that help them survive and spread between hosts. However, the presence of a pathogen does not always result in infection because the other links in the chain of transmission must also be present.

Different pathogens can survive in the environment for varying lengths of time. Influenza may remain on inanimate surfaces for up to 48 hours, while *Clostridioides difficile* spores may survive for months or years if surfaces are not cleaned properly. Some people who are infected develop noticeable symptoms, while others remain asymptomatic and show no signs of infection.

The infectious-agent link in the chain of transmission can be interrupted by cleaning, disinfecting, or sterilizing the environment according to the type of pathogen and organizational policies. Prescribed medications may also be used to eliminate or control the infectious agent.



Reservoir

A reservoir is a living organism or inanimate object where an infectious agent lives, survives, multiplies, and grows. Reservoirs may include people, animals, insects, food, soil, and water. A person carrying a pathogen may or may not be able to transmit it, depending on the pathogen and the stage of infection.

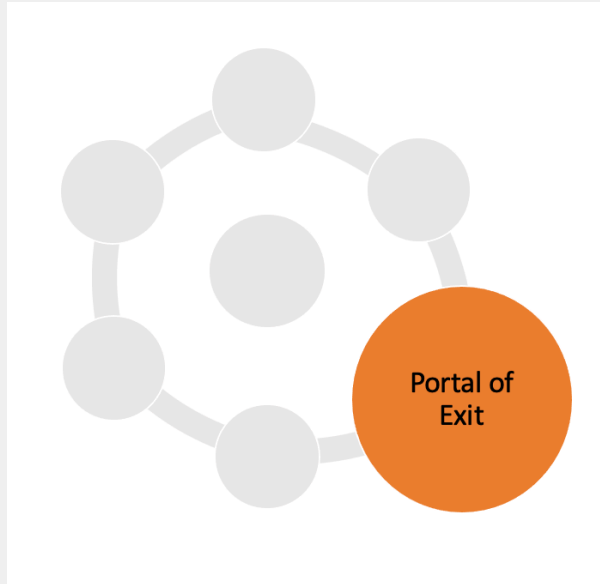
Examples of reservoirs include people whose upper respiratory tracts contain the influenza virus. Influenza may also survive on inanimate surfaces for up to 48 hours after being released through actions such as sneezing. Animals can serve as reservoirs for infections such as rabies, which may be transmitted to humans through a bite from an infected animal. The rabies virus does not survive outside its host. Mosquitoes carry malaria parasites and may transmit them to humans through bites.

Food can become contaminated through poor hand hygiene, inadequate washing, undercooking, or cross-contamination. Consuming contaminated food may result in a foodborne infection and gastrointestinal illness. Soil may contain fungal pathogens such as those that cause blastomycosis or bacteria associated with tetanus. People may become infected by breathing in spores from contaminated soil. Contaminated water may contain *Giardia* parasites, which can infect people when the water is consumed.

The reservoir link in the chain of infection can be interrupted by cleaning, disinfecting, or sterilizing the environment according to the pathogen and workplace policies. Stethoscopes, medical equipment, and other reusable items should be disinfected between clients. Frequently touched surfaces in client rooms, such as bed rails, doorknobs, and call bells, should also be disinfected, along with shared facilities such as toilets and sinks.

Safe food handling and storage practices can also help interrupt the reservoir link. Hand hygiene should be performed before handling food, food should be washed as appropriate, and eating surfaces should be cleaned before use. Clients who cannot complete personal hygiene

independently because of limited mobility, cognitive impairment, or their medical condition should receive assistance. Clients should also be taught about hand hygiene, respiratory etiquette, and the importance of vaccination in preventing the spread of infection.



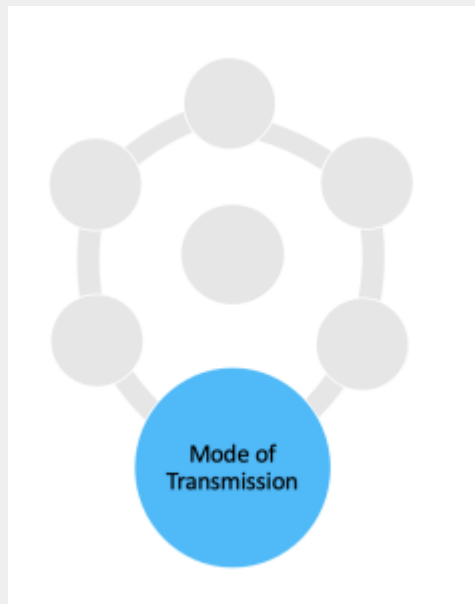
Portal of Exit

A portal of exit is the route through which an infectious agent leaves its reservoir or host. Portals of exit may include the mouth through saliva or vomit; the respiratory tract through coughing, sneezing, talking, or laughing; skin lesions through blood or exudate; and the gastrointestinal or genitourinary tracts through urine, feces, semen, or vaginal secretions.

Once an infectious agent leaves the body, it may be transmitted if it enters another person through the eyes, nose, or mouth or contaminates an object or environmental surface.

The portal-of-exit link in the chain of infection can be interrupted by performing hand hygiene and following Routine Practices. Clients should be taught respiratory etiquette, including covering coughs and sneezes, avoiding coughing or sneezing into their hands, performing hand hygiene, and disposing of used tissues promptly.

Wounds should be covered to contain blood or drainage. Contaminated linens and waste should be placed in the appropriate receptacles, particularly when a client is incontinent of urine or stool. When assisting with personal hygiene, care should proceed from the cleanest areas of the body to the dirtiest areas, such as during bathing or perineal care.



Mode of Transmission

The mode of transmission describes how an infectious agent travels and spreads from one person to another, either directly or indirectly. The main modes of transmission are contact, droplet, airborne, vehicle, and vector transmission.

Contact transmission occurs directly when a person touches an infectious client or indirectly when they touch contaminated objects, surfaces, or medical equipment. When caring for a client on contact precautions, such as a client with methicillin-resistant *Staphylococcus aureus* (MRSA), gloves and a gown are required when the health-care provider's skin or clothing may come into contact with the client or the contaminated environment.

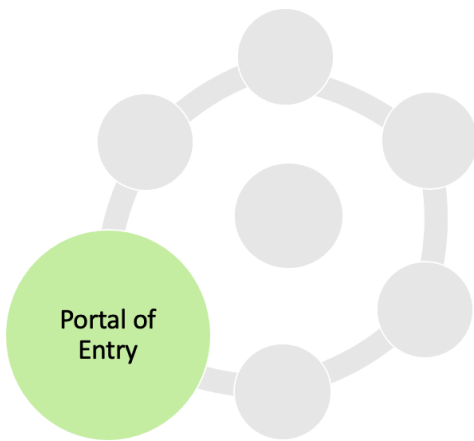
Droplet transmission occurs when respiratory secretions are released through talking, sneezing, coughing, or laughing. These droplets may travel up to two metres. Clients with infections such as influenza, pertussis, rubella, or mumps may require droplet precautions. Health-care providers must wear a medical mask and eye protection when working within two metres of the client.

Airborne transmission occurs through small infectious particles that can remain suspended in the air and travel distances greater than two metres. A client with an airborne infection such as tuberculosis must be placed in a negative-pressure room. Health-care providers must wear a fit-tested and seal-checked N95 respirator when entering the room.

Vehicle transmission occurs when infectious agents are spread through substances such as food, water, or air. Vector transmission occurs when living organisms carry infectious agents between hosts. Biological vectors, such as mosquitoes, may transmit an infectious agent as part of their life cycle. Mechanical vectors, such as flies or ticks, may carry an infectious agent from an animal or contaminated source to a person.

The mode-of-transmission link in the chain of infection can be interrupted by performing hand hygiene and following Routine Practices and Additional Precautions as required. Contaminated objects and surfaces, including stethoscopes, client charts, and doorknobs, must be cleaned, disinfected, or sterilized according to the pathogen and the health-care organization's policies.

Appropriate physical separation should be maintained between clients who share a room or are placed in a cohort area. Negative-pressure room procedures must be followed to prevent airborne pathogens from travelling outside the room. Health-care providers should know their immunity status when caring for clients with infections such as measles. Clients should also receive education about the importance of immunization in preventing infectious diseases.



Portal of Entry

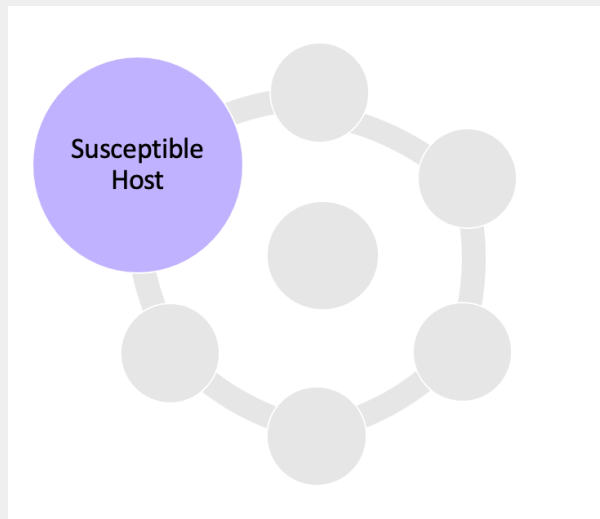
A portal of entry is the route through which an infectious agent enters another person's body or a new host. Infectious agents may enter through the mucous membranes of the eyes, nose, or mouth, through the respiratory or digestive systems, or through broken skin and open wounds.

Invasive devices can create portals of entry. Examples include urinary catheters, gastrostomy tubes, intravenous catheters, and other devices that enter the body. Bacteria may enter through non-intact skin on a client or health-care provider. Viruses may enter the mucous membranes of the eyes, nose, mouth, or respiratory tract when an infected person coughs or sneezes without covering their face while near another person. Infectious agents may also enter the digestive system when a person consumes contaminated food.

The portal-of-entry link in the chain of infection can be interrupted by performing hand hygiene and following Routine Practices and Additional Precautions as required. Health-care providers should use aseptic technique during procedures such as catheter insertion, central intravenous

line care, and certain wound-dressing procedures. Contaminated equipment and environments must be cleaned, disinfected, or sterilized according to workplace policies.

When teaching or assisting clients with personal hygiene, care should progress from the cleanest areas of the body to the dirtiest areas. This principle applies to procedures such as bathing and perineal care and helps reduce the transfer of microorganisms to vulnerable areas of the body.



Susceptible Host

A susceptible host is anyone who is at risk of being affected by an infectious agent, although some people are more vulnerable than others. Individuals at increased risk include newborns, children under five years of age, pregnant people, adults over 65, unimmunized individuals, people undergoing invasive procedures or complex treatments, and those with chronic illnesses or compromised immune systems.

In health-care settings, factors that increase a client's risk of becoming colonized or infected include advanced age, greater illness severity, invasive procedures, immunosuppression, frequent exposure to microorganisms, complex treatments, and increased use of antimicrobial medications.

When an infectious agent enters a susceptible host, the response may differ from person to person. Some individuals may remain asymptomatic and show no signs of infection, while others may develop a range of symptoms.

The susceptible-host link in the chain of infection can be interrupted by identifying people at increased risk and protecting their natural defences. Strategies include covering open wounds, keeping drainage systems closed and intact, maintaining skin integrity, and following aseptic

practices. Supporting a healthy lifestyle through proper nutrition, physical activity, adequate rest and sleep, effective coping strategies, and current vaccinations can also reduce susceptibility to infection.

To stop the transmission of an infectious agent, at least one link must be broken. To help determine how to break the chain of transmission, perform a risk assessment with every client, in every situation, and in all healthcare settings. When consistently following infection prevention and control measures, you can eliminate the transmission of infectious agents.

Points of Consideration

Healthcare Providers and Infectious Agents

Healthcare providers are vulnerable to infectious agents. As a healthcare provider, you need to understand your risk of exposure to healthcare-associated infections. One strategy to decrease your risk is staying up to date with your immunizations. Are you up to date with your vaccinations? Are you a vulnerable person?

Another strategy to decrease your risk of HAI is to wear the appropriate PPE. Do you have access to the appropriate PPE required for care? When caring for clients, are you wearing the appropriate PPE? The majority of infections among healthcare providers occur due to improper removal of PPE.

There should be sufficient and accessible PPE in your workplace. If you are unable to access the appropriate PPE, inform your placement preceptor or instructor, the healthcare setting supervisor or manager, and occupational health for further assistance on the specific procedures to obtain the required PPE.

It is important to reflect on your infection prevention and control practices, be aware of the policies and procedures at your healthcare facility, and maintain competency in your infection prevention and control knowledge and skills.

From Theory to Practice

Read the case studies below and use your knowledge to choose the correct answers.

Text Description

This four-part case-based activity presents a four-year-old child brought to the emergency department with symptoms of a possible influenza infection. Learners review the child's health information and answer questions about infectious agents, precautions, the chain of transmission, and portals of exit.

An accompanying photograph shows a smiling young child with braided hair wearing a light-coloured shirt and sitting against a plain wall.

Part 1: Client Information

The activity presents the following case:

Biographical data: A four-year-old child.

Reason for seeking care: The child was brought to the emergency department by a parent. The child has been drowsy for the past 24 hours and has a tympanic temperature of 38.9°C. No medication has been given.

History of presenting illness: The child has experienced diarrhea, has not eaten for 36 hours, and has consumed only a small amount of water. The child has a fever, an elevated heart rate, a runny nose, and a dry cough. Their lips are dry and cracked, they have not urinated for 10 hours, and they are lethargic.

Medical history: No known illness or disease.

Based on the child's symptoms, the health-care provider places the child on droplet and contact precautions for suspected influenza.

Part 2: Identifying the Infectious Agent

The learner is asked: What type of infectious agent is influenza?

The answer choices are:

- Bacteria
- Virus
- Fungi
- Parasite
- Prion
- Solution

Correct response: Virus.

Influenza is caused by a virus. Other viral infections include varicella, commonly known as chickenpox.

Part 3: Breaking the Chain of Transmission

During the physical assessment, the child sneezes and coughs onto the health-care provider's stethoscope.

The learner is asked: What action should the health-care provider take to break the chain of transmission? Select all that apply.

The answer choices are:

- Sterilize the stethoscope.
- Disinfect the surrounding environment.
- Wear appropriate personal protective equipment.
- Perform hand hygiene.
- Teach the client and caregiver about respiratory etiquette.
- Place the client in a negative-pressure room.

Solution

The correct responses are:

- Disinfect the surrounding environment.
- Wear appropriate personal protective equipment.
- Perform hand hygiene.
- Teach the child and caregiver about respiratory etiquette.

The stethoscope and other medical equipment should be cleaned and disinfected between clients. Frequently touched surfaces, including bed rails, doorknobs, call bells, toilets, and sinks, should also be disinfected according to organizational policy.

The health-care provider should perform a point-of-care risk assessment before entering the room to determine the required personal protective equipment. Hand hygiene should be performed before and after client care.

The child and caregiver should receive age-appropriate teaching about respiratory etiquette, including covering coughs and sneezes and performing hand hygiene.

Sterilization of the stethoscope is not required. A negative-pressure room is also not required because influenza is not managed using airborne precautions.

Part 4: Identifying the Portal of Exit

The learner is told that a portal of exit is the route through which an infectious agent leaves its reservoir or host.

The learner is asked: What is the portal of exit for this client case? Select all that apply.

The answer choices are:

- Sneezing
- Coughing
- Saliva
- Diarrhea
- Sweating

Solution

The correct responses are:

- Sneezing
- Coughing
- Saliva

Respiratory droplets and secretions leave the child's body through coughing, sneezing, and saliva. In this scenario, diarrhea and sweating are not identified as portals of exit associated with the suspected influenza infection.

Text Description

This four-part case-based activity presents a 27-year-old health-care provider who experiences a needlestick injury while changing the soiled bed linen of a client diagnosed with hepatitis B. Learners apply concepts related to the chain of infection and identify strategies for reducing the risk of infection.

An accompanying photograph shows a smiling young adult with straight dark hair, wearing a white top.

Part 1: Client Information

The activity presents the following case:

Biographical data: A 27-year-old health-care provider.

Reason for seeking care: The health-care provider experienced a needlestick injury while changing the soiled bed linen of a client diagnosed with hepatitis B.

History of presenting illness: The injury occurred 15 minutes earlier. The health-care provider washed the affected area thoroughly with soap and water, allowed the site to bleed freely, and then went to the emergency department.

Medical history: Arthritis.

Part 2: Identifying the Reservoir

The learner is asked: A reservoir can be a living organism or an inanimate object where an infectious agent lives, survives, and can multiply and grow. In this case, what is the reservoir?

The answer choices are:

- The client
- The soiled linen
- The needle
- The health-care provider

Solution

Correct response: The client.

The client is the reservoir because the hepatitis B virus lives, survives, and multiplies in the infected client. The needle and soiled linen may become contaminated but are not the reservoir. The health-care provider is the susceptible host in this scenario.

Part 3: Identifying the Mode of Transmission

The learner is asked: The mode of transmission is how the infectious agent travels and spreads

from one person to another, either directly or indirectly. What is the mode of transmission in this case?

The answer choices are:

- Contact
- Droplet
- Airborne
- Vehicle
- Vector

Solution

Correct response: Contact.

A needlestick injury is considered indirect contact transmission. The contaminated needle can transfer pathogens from an infected person to another individual. Safe sharps disposal and appropriate vaccination help reduce the risk of transmission.

Part 4: Reducing the Risk of Infection

A reflection card asks: How can the health-care provider decrease the risk of infection?

Solution

The health-care provider's initial response was appropriate:

- Wash the affected area thoroughly with soap and water.
- Allow the injury site to bleed freely.
- Seek immediate assessment in the emergency department.
- Complete the required assessment to determine immediate treatment, possible prophylaxis, follow-up care, and prevention education.
- Ensure hepatitis B vaccination and immunity are current.
- Perform a point-of-care risk assessment before providing care to identify possible exposure to blood or body fluids and determine the personal protective equipment required.

Text Description

This three-part case-based activity presents a 65-year-old client admitted to a rehabilitation unit after a motor vehicle accident. Learners apply concepts related to the chain of infection, portals of entry, infection-control measures, and modes of transmission.

An accompanying photograph shows a smiling older adult with short white hair wearing dark sunglasses and a blue striped shirt outdoors.

Part 1: Client Information

The activity presents the following case:

Biographical data: A 65-year-old man.

Reason for seeking care: The client was admitted to a rehabilitation unit after being involved in a motor vehicle accident.

History of presenting illness: The client experienced prolonged bed rest because of his injuries

and required an indwelling urinary catheter to support urinary elimination.

Medical history: Diabetes.

Part 2: Identifying the Portal of Entry

The learner is asked: The portal of entry is how the infectious agent enters another person's body or a new host. In this case, what would be considered a portal of entry?

The answer choices are:

- Diabetes
- The client
- The catheter
- Prolonged bed rest

Solution

Correct response: The catheter.

A catheter or other invasive device can provide a route through which an infectious agent enters the body.

Diabetes and prolonged bed rest may make the client more susceptible to infection, but they are not portals of entry. The client may act as a reservoir where an infectious agent lives and multiplies.

Part 3: Breaking the Portal-of-Entry Link

The health-care provider enters the client's room to assist with morning care.

The learner is asked: How can you break the link of the portal of entry? Select all that apply.

The answer choices are:

- Perform hand hygiene.
- Ensure the client is up to date on vaccinations.
- Apply aseptic techniques as required.
- Dispose of contaminated linens if the client is incontinent of stool.
- Disinfect and sterilize contaminated items.

Solution

The correct responses are:

- Perform hand hygiene.
- Apply aseptic techniques as required.
- Disinfect and sterilize contaminated items.

Hand hygiene should be performed before and after client care. Aseptic technique is used during procedures such as catheter insertion, central intravenous line care, and certain wound-dressing procedures. Contaminated equipment and environmental surfaces should be disinfected or sterilized according to organizational policies.

Vaccination helps interrupt the susceptible-host link rather than the portal-of-entry link. Proper handling of contaminated linens helps interrupt the portal-of-exit or transmission links.

Part 4: Identifying the Mode of Transmission

While in the hospital, the client tests positive for tuberculosis.

The learner is asked: What is the mode of transmission?

The answer choices are:

- Contact
- Droplet
- Airborne
- Vehicle
- Vector

Solution

Correct response: Airborne.

Tuberculosis is transmitted through small infectious particles that can remain suspended in the air and travel beyond two metres. A client with tuberculosis requires airborne precautions, including placement in a negative-pressure room and the use of a fit-tested, seal-checked N95 respirator by health-care providers entering the room.

The *Chain of Transmission* section is adapted from “Chain of Transmission” in Introduction to Infection Prevention and Control Practices for the Interprofessional Learner, Copyright©(2021) by Michelle Hughes; Audrey Kenmir; Oona St-Amant; Caitlin Cosgrove; and Grace Sharpe, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted.

7.3 Standard Precautions

Interventions to Break the Chain of Infection

Infections can be stopped from spreading by interrupting this chain at any link. Chain links can be broken by disinfecting the environment, sterilizing medical instruments and equipment, covering coughs and sneezes, using good hand hygiene, implementing standard and transmission-based precautions, appropriately using personal protective equipment, encouraging clients to stay up-to-date on vaccines (including the flu shot), following safe injection practices, and promoting the optimal functioning of the natural immune system with good nutrition, rest, exercise, and stress management.

Disinfection and Sterilization

Disinfection and sterilization are used to kill microorganisms and remove harmful pathogens from the environment and equipment to decrease the chance of spreading infection. Disinfection is the removal of microorganisms. However, disinfection does not destroy all spores and viruses. Sterilization is a process used on equipment and the environment to destroy all pathogens, including spores and viruses. Sterilization methods include steam, boiling water, dry heat, radiation, and chemicals. Because of the harshness of these sterilization methods, skin can only be disinfected and not sterilized (CDC, 2023).

Standard and Transmission-Based Precautions

To protect clients and health care workers from the spread of pathogens, the CDC has developed precautions for client care that address portals of exit, routes of transmission, and portals of entry. These precautions include standard precautions and transmission-based precautions.



Standard Precautions

Standard precautions are used when caring for all clients to prevent healthcare-associated infections. According to the Centers for Disease Control and Prevention (CDC), standard precautions are the minimum infection prevention practices that apply to all client care, regardless of suspected or confirmed infection status of the client, in any setting where health care is delivered. These precautions are based on the principle that all blood, body fluids (except sweat), nonintact skin, and mucous membranes may contain transmissible infectious agents. These standards reduce the risk of exposure for the health care worker and protect the client from potential transmission of infectious organisms (CDC, 2024a). See *Figure 7.3.1* for an image of some of the components of standard precautions.

Current standard precautions according to the CDC include the following (CDC, 2024a):

- Appropriate hand hygiene
- Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) whenever infectious material exposure may occur
- Appropriate client placement and care using transmission-based precautions when indicated
- Respiratory hygiene/cough etiquette
- Proper handling and cleaning of the environment, equipment, and devices
- Safe handling of laundry and textiles
- Safe injection practices (CDC, 2024b)



Figure 7.3.1: Components of Standard Precautions

7.3.1 Hand Hygiene

Hand hygiene is the most important part of practice for health care workers and is the single most effective way to stop the spread of infections; failure to properly perform hand hygiene is the leading cause of HAIs and the spread of multi-drug-resistant organisms (MDROs) (BC Centre for Disease Control, 2014; WHO, 2009a).

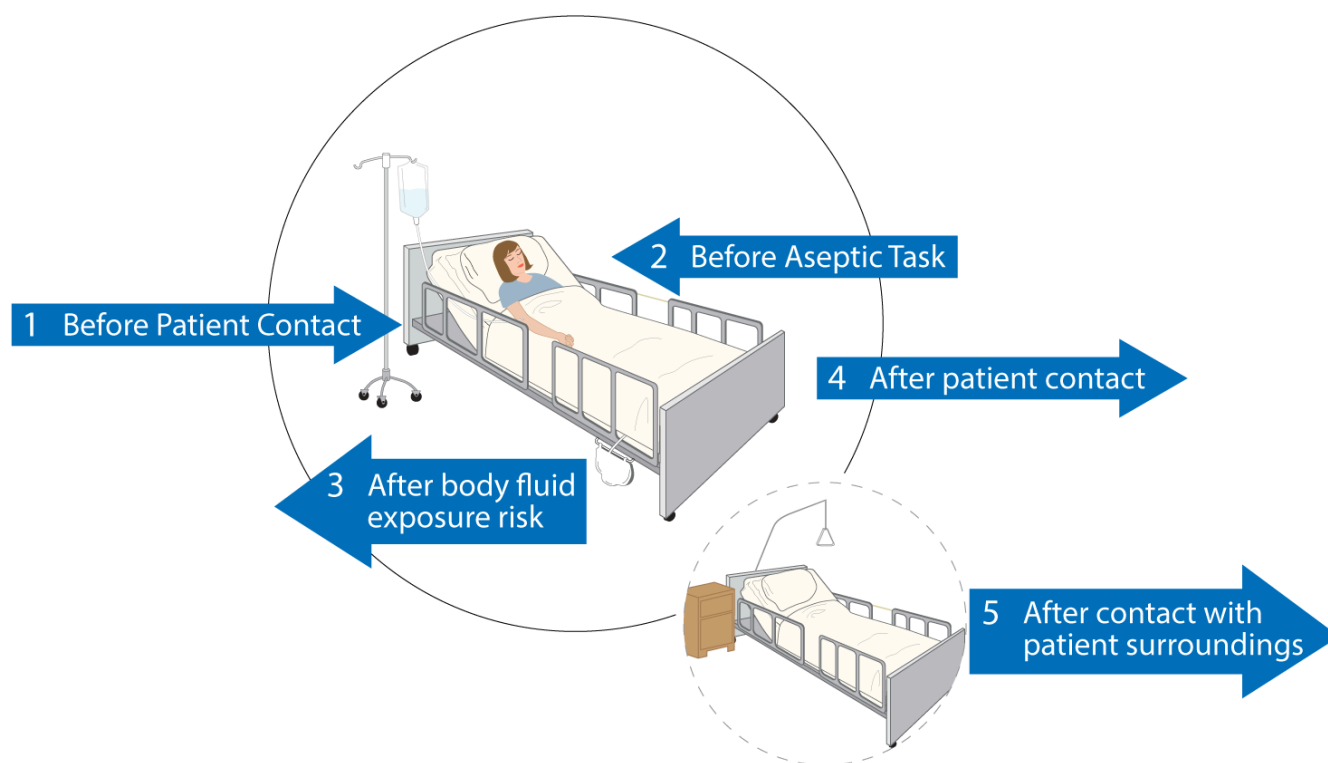
Hand hygiene is a general term used to describe any action of hand cleaning and refers to the removal or

destruction of soil, oil, or organic material, as well as the removal of microbial contamination acquired by contact with patients or the environment. Hand hygiene may be performed using an alcohol-based hand rub (ABHR) or soap and water. A surgical hand scrub is also a method of hand hygiene (WHO, 2009a).

To break the chain of infection, there are five key moments at which to perform hand hygiene when working in health care, as outlined in Table 7.3.1 and illustrated in *Figure 7.3.2*.

Table 7.3.1: Five Key Moments in Hand Hygiene

Disclaimer: Always review and follow your hospital policy regarding this specific skill.	
Safety considerations: • If contact dermatitis occurs, use soap and water for hand hygiene. • Instruct patients and family on the importance of hand hygiene, proper technique, and ways to incorporate routines into everyday practice. • Certain practices can increase the risk of skin irritation and should be avoided. For example, washing hands regularly with soap and water immediately before or after using an alcohol-based product is not only unnecessary but may lead to dermatitis. • Always wash your hands whenever in doubt.	
Key Moments	Additional Information
1. Before initial contact with the patient/client/resident or the environment contact	Before touching a patient (e.g., feeding, toileting, or personal care) Before touching the patient's environment Before adjusting an IV rate Before taking a pulse or blood pressure
2. Before any clean (routine) or aseptic (sterile) procedure	Before applying clean or sterile gloves Before performing a sterile dressing change Before feeding a patient Before performing oral/dental care Before inserting eye drops Before inserting a Foley catheter Before preparing medication
3. After blood or body fluid risk/exposure	After contact with body secretions, mucous membranes, or non-intact skin After glove removal (clean or sterile gloves) After handling waste (urine, drainage, wound care) After wound care or a sterile procedure When moving from a contaminated area on the body to a non-contaminated area
4. After contact/touching the patient/client/resident	After taking a blood pressure or pulse, touching a urinary catheter, or feeding or dressing a patient
5. After contact with the patient's/client's/resident's environment	After touching a bedside table or bathroom light After touching personal toiletries After touching walkers or wheelchairs After touching electronic IV devices After taking blood pressure or pulse After changing bed linen



1 Before Patient Contact	When? Clean your hands before touching a patient when approaching him or her Why? To protect the patient against harmful germs carried on your hands
2 Before An Aseptic Task	When? Clean your hands immediately before any aseptic task Why? To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3 After Body Fluid Exposure Risk	When? Clean your hands immediately after an exposure risk to body fluids (and after glove removal) Why? To protect yourself and the health-care environment from harmful patient germs
4 After Patient Contact	When? Clean your hands after touching a patient and his or her immediate surroundings when leaving Why? To protect yourself and the health-care environment from harmful patient germs
5 After Contact With Patient Surroundings	When? Clean your hands after touching any object or furniture in the patients immediate surroundings, when leaving - even without touching the patient Why? To protect yourself and the health-care environment from harmful patient germs

Figure 7.3.2: Five moments in hand hygiene

Image Description

Five Moments for Hand Hygiene

Diagram Labels

1. Before Patient Contact
2. Before Aseptic Task
3. After body fluid exposure risk
4. After patient contact
5. After contact with patient surroundings

1. Before Patient Contact

When? Clean your hands before touching a patient when approaching him or her.

Why? To protect the patient against harmful germs carried on your hands.

2. Before an Aseptic Task

When? Clean your hands immediately before any aseptic task.

Why? To protect the patient against harmful germs, including the patient's own germs, entering their body.

3. After Body Fluid Exposure Risk

When? Clean your hands immediately after an exposure risk to body fluids (and after glove removal).

Why? To protect yourself and the health-care environment from harmful patient germs.

4. After Patient Contact

When? Clean your hands after touching a patient and his or her immediate surroundings when leaving.

Why? To protect yourself and the health-care environment from harmful patient germs.

5. After Contact With Patient Surroundings

When? Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving—even without touching the patient.

Why? To protect yourself and the healthcare environment from harmful patient germs.

Non-sterile (Clean) Gloves

Both hand hygiene and clean glove use are strategies to prevent transmission of infections through hand contact. In the context of patient care, it makes sense to think of glove use and hand hygiene as complementary strategies to prevent transmission of pathogens. Gloves are critical to prevent the transmission of organisms when hand hygiene alone is not enough in an outbreak such as *Clostridium difficile* or the norovirus, or when a patient has a suspected or known pathogen. Studies have shown that gloves reduce transmission of microbes from the hands of health care workers (PIDAC, 2012).

Non-sterile gloves are single-use and should be applied:

- Before an aseptic procedure
- When anticipating contact with blood or body fluid, non-intact skin, secretions, excretions, mucous membranes, or equipment/environmental surfaces contaminated with the above blood or body fluids
- When in contact with a patient or patient equipment/environment, additional precautions

Non-sterile gloves should be removed:

- If gloves are damaged and their integrity is compromised
- When contact with blood, body fluid, non-intact skin, or mucous membranes has ended
- When contact with a single patient and that patient's surroundings or a contaminated body site on a patient has ended
- When there is an indication for hand hygiene

See Table 7.3.2 for steps on how to apply non-sterile gloves.

Checklist 7.3.2: Applying Non-Sterile Gloves

Disclaimer: Always review and follow your hospital policy regarding this specific skill.

Safety considerations:

- Hands must be clean and dry before putting on gloves. Gloves do not replace the need for hand hygiene.
- Hand hygiene must be performed every time gloves are removed. Gloves are not completely free of leaks or 100% tear-proof, and hands may become contaminated when gloves are removed.
- Gloves are for single-patient use and must be removed after caring for one patient. Reuse of gloves has been associated with transmission of antibiotic-resistant organisms.
- Change or remove gloves if moving from a contaminated site to a non-contaminated site on the same person or if touching the environment.
- Wear gloves that fit properly. Different sizes are available.
- Gloves must be removed immediately and discarded in a waste bin after the activity for which they were used and before exiting a patient's environment.
- Gloves are not required for health care activities where contact is limited to intact skin, such as taking blood pressure.
- Indiscriminate or improper glove use (e.g., wearing gloves all the time) has been linked to transmission of pathogens.
- Gloves should fit snugly around wrists and hands for use with a gown to provide a better skin barrier.

Steps	Additional Information
1. Perform hand hygiene.	 <i>Hand hygiene with ABHR</i>
2. Select the appropriate size of non-sterile gloves. Remove gloves one at a time out of the box, touching only the top of the cuff.	 <i>Remove gloves from the box</i>

3. Put your hand through the opening and pull up to the wrist.	 <i>Apply the first glove</i>
4. Repeat the procedure with the second hand.	 <i>Apply the second glove</i>
5. Adjust gloves to cover wrists or gown as required.	Prevents the contamination of the wrists.
6. Complete care as required.	 <i>Non-sterile gloved hands</i>
How to Remove Gloves	

1. Grasp the glove on the outside about 1/2 inch below the cuff (edge of the glove opening). Do not touch the wrist with the other hand.



Grasp the glove on the outside 1/2 inch below the cuff

2. Pull down the glove, turning it inside out. Hold the inside-out glove in the gloved hand.



Pull the glove off ...



... inside out

3. Gather the inside-out glove in the gloved hand.



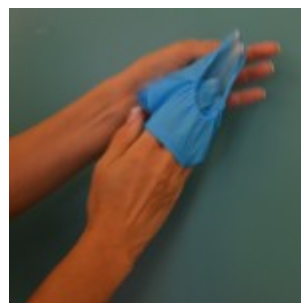
Gather the inside-out glove in the remaining gloved hand

4. Insert the finger of the bare hand under the cuff of the gloved hand.



Insert finger under the cuff of the gloved hand

5. Pull down the glove until it is inside out, drawing it over the first glove.



Remove the second glove

6. Discard gloves in a garbage container.	This step reduces the spread of microorganisms.  <i>a person holding gloves to discard</i> <i>Discard used non-sterile gloves</i>
7. Perform hand hygiene.	This step reduces the spread of microorganisms.  <i>Hand hygiene with ABHR</i>
Data source: Braswell & Spruce, 2012; PIDAC, 2012; Poutanen, Vearncombe, McGeer, Gardam, Large, & Simor, 2005; PHAC, 2012a; WHO, 2009a	



Watch: Your 4 Moments for Hand Hygiene

Video: “Your 4 Moments for Hand Hygiene (Hospitals)” by Public Health Ontario [21:41] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Link to Learning

Just Clean Your Hands Videos & Resources from PHO

From Theory to Practice

Hand Hygiene Interactive Video

In this interactive video, you will have the opportunity to test your knowledge of handwashing. As you watch the interactive video, you will be asked questions throughout the skill demonstration. You must answer the questions correctly before you can move forward. Don't forget to review the rationales for your decisions with each question.

Have fun playing!

Please note: there is no sound in this video.

Video: "Performing Alcohol-Based Hand Rub" by Michelle H [0:43] is licensed under the Standard YouTube License.

Video Description and Transcript

This interactive video demonstrates proper handwashing technique at a sink. It includes embedded questions that reinforce preparation, water temperature and flow, hand positioning, contamination prevention, rinsing, drying, faucet handling, and completion of the procedure.

Video description:

Before beginning, fingernails should be short and free of nail polish or artificial nails. Jewellery should be removed, hair should be secured off the shoulders, and the hands, wrists, and cuticles should be inspected for visible soiling, cuts, or lesions. The uniform should not touch the sink.

The water should be warm and set at a medium flow to reduce splashing. The hands and wrists are thoroughly wetted before soap is applied. Enough soap is used to cover all surfaces, and the hands are rubbed together for at least 20 seconds.

Friction is applied using circular motions while cleaning the palms, backs of the hands, between the fingers, around the thumbs and small fingers, over the knuckles, beneath the fingernails, and around the wrists. The hands and forearms remain lower than the elbows. If the hands touch the contaminated sink, the soap should be rinsed off, and the procedure started again.

The soap is rinsed away while keeping the hands down and the elbows up. The hands are dried thoroughly with paper towel, moving in one direction from the fingertips toward the wrists. A clean, dry paper towel is then used to turn off the faucet.

The final step is to inspect the hands and wrists to confirm that all visible soiling has been removed and all surfaces are dry.

Embedded questions and correct answers:

1. **What should you do before you begin to wash your hands? Select all that apply. Correct answers:** Keep fingernails short; assess the hands for visible soiling; keep hair off the shoulders;

and inspect the hands for cuts or lesions. All rings and bracelets should be removed, rather than removing only jewellery with stones.

2. **What is the appropriate flow and water temperature when washing your hands? Correct answer:** A medium flow and warm water.
3. **True or false: You need to keep your hands and forearms lower than your elbows. Correct answer:** True.
4. **What should you do if your hands touch the sink while you are washing them? Correct answer:** Rinse off the soap and repeat the procedure from the beginning.
5. **Complete the statement: Keep your hands ____ and your elbows ____ while rinsing away the microorganisms. Correct answer:** Keep your hands **down** and your elbows **up**.
6. **How should you dry your hands? Select all that apply. Correct answers:** Dry the hands thoroughly and move from the fingertips toward the wrists in one direction.
7. **True or false: You should use a dry, clean paper towel when turning off the faucet. Correct answer:** True.
8. **What is the final step in performing hand hygiene? Correct answer:** Inspect the hands to ensure that all soiling has been removed and all surfaces are dry.

Alcohol-Based Hand Rub Interactive Video

During this interactive video, you will have the opportunity to test your knowledge on performing an alcohol-based hand rub. As you watch the interactive video, you will be asked questions throughout the performance of the skill. You must answer the questions correctly before you're able to move forward. Don't forget to review the rationales for your decisions with each question.

Play on!

Please note: there is no sound in this video.

Video: "Hand Washing Video" by Michelle H [2:25] is licensed under the Standard YouTube License.

Video Description and Transcript

This interactive video demonstrates how to perform hand hygiene using an alcohol-based hand rub. It includes embedded questions and teaching notes about the correct application technique, the length of time required, and when alcohol-based hand rub should or should not be used.

Video description:

The demonstration shows alcohol-based hand rub being applied to the hands. Usually, one to two pumps of the product are needed to provide enough solution to cover all surfaces. The hands are rubbed together so that the product covers the palms, backs of the hands, fingers, spaces between the fingers, fingernails, thumbs, and wrists.

The hands should be rubbed together for at least 15 to 30 seconds and until the solution has completely dried. Alcohol-based hand rub is the preferred method of hand hygiene when the hands are not visibly soiled. The product should contain at least 60% alcohol to be effective.

Alcohol-based hand rub does not eliminate every type of microorganism. Soap and water are more effective when the hands are visibly soiled or when caring for a client who is diagnosed with or

suspected of having *Clostridioides difficile*, norovirus, cryptosporidium, or certain other germs that can cause diarrhea.

Embedded questions and correct answers:

1. **When hands are not visibly soiled, alcohol-based hand rub is less effective than washing your hands with soap and water. Correct answer:** False. Alcohol-based hand rub is generally more effective than soap and water when the hands are not visibly soiled. Alcohol-based hand sanitizers must contain at least 60% alcohol to be effective.
2. **Alcohol-based solution must cover all surfaces of your hands. Rub your hands for a minimum of how many seconds, until the solution becomes dry? Correct answer:** 15 to 30 seconds. Usually, one to two pumps of the alcohol-based solution are needed to cover all surfaces of the hands, fingers, nails, and wrists.
3. **Teaching note:** It is important to cover all surfaces of the hands, fingers, nails, and wrists when performing an alcohol-based hand rub. The sanitizer must contain at least 60% alcohol. Rub the hands together for at least 15 to 30 seconds, until the solution feels dry.
4. **What are the benefits of performing an alcohol-based hand rub when the hands are not visibly soiled? Select all that apply. Correct answers:**
 - It takes less time.
 - It is less drying to the hands.
 - It is more effective than soap and water when the hands are not visibly soiled.

Incorrect answer: It removes all bacteria and viruses. Alcohol-based hand sanitizers do not eliminate all types of microorganisms. Soap and water may be required for specific organisms, including *Clostridioides difficile*, norovirus, and cryptosporidium.

5. **True or false: Alcohol-based hand rub is the preferred method of hand hygiene when your hands are not visibly soiled. Correct answer:** True.

Summary of key points:

- Alcohol-based hand rub is the preferred hand hygiene method when the hands are not visibly soiled.
- Use enough product to cover the hands, fingers, fingernails, thumbs, and wrists.
- Rub the hands together for at least 15 to 30 seconds and until the product is dry.
- Alcohol-based hand sanitizer should contain at least 60% alcohol.
- Alcohol-based hand rub takes less time, is generally less drying to the hands, and is more effective than soap and water when the hands are not visibly soiled.
- Soap and water are more effective for visibly soiled hands and for certain microorganisms, including *Clostridioides difficile*, norovirus, and cryptosporidium.

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The 7.3.1 *Hand Hygiene* section is adapted from “1.3 Hand Hygiene” in Clinical Procedures for Safer Patient Care

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7.4 Additional (Transmission-Based) Precautions

Certain pathogens and communicable diseases are easily transmitted and require additional precautions to interrupt the spread of suspected or identified agents to health care providers, other patients, and visitors (PIDAC, 2012). Additional precautions are used in addition to routine precautions and are defined by how a microorganism is transmitted (Perry et al., 2014).

Types of Additional Precautions

There are three categories of additional precautions: contact precautions, droplet precautions, and airborne precautions.

Contact Precautions

These are the most common types of additional precautions. They are used in addition to routine practice for patients known or suspected to be infected with microorganisms that can be transmitted by direct (touching) or indirect (shared equipment) contact. Types of organisms in this category include *antibiotic-resistant organisms (AROs)*, such as *methicillin-resistant Staphylococcus aureus (MRSA)*, *vancomycin-resistant Enterococci (VRE)*, extended-spectrum beta-lactamase (ESBL)-producing organisms, *Clostridium difficile (CDI)*, and carbapenemase-producing organisms (CPOs), as well as diarrhea and scabies. AROs are also known as multi-drug-resistant organisms (MDROs).

Droplet Precautions

They are used in addition to routine practices for patients known or suspected to be infected with microorganisms spread through the air by large droplets. Types of organisms and unconfirmed conditions in this category include mumps, influenza, vomiting of unknown cause, norovirus, and unconfirmed cough.

Airborne Precautions

They are used in addition to routine practices for patients known to have, or suspected of having, an illness transmitted by small droplet nuclei that may remain suspended in the air and be inhaled by others. These particles can remain infectious for a long period of time when spread through the air. Types of organisms in this category include tuberculosis (TB), measles, chicken pox (varicella), disseminated zoster, and severe acute respiratory syndrome (SARS).

Special considerations:

- Signage and accommodation: Signs must state the type of precaution required for the patient and be displayed on the door or at the foot of the bed. Accommodation in a private room or cohorting patients with the same type of infection is acceptable. Private bathrooms are preferred.
- Personal protective equipment (PPE): PPE is clothing or equipment worn to protect staff from catching or transmitting an infection. Depending on the type of additional precaution, PPE required when performing patient care tasks may consist of a mask, gown, gloves, face shield, and/or eyewear.
- Consistent communication: Patients on additional precautions must be clearly identified on their patient chart or requisitions to ensure all hospital personnel, departments, or other health care settings know what additional precautions to use.
- Visitor information: Visitors must be informed of the precautions and must wear the appropriate PPE and follow the routine practices for health care settings. Visitors also must wear the same PPE as the health care provider if providing direct care for the patient.
- Multiple additional precautions: Some microorganisms may be transmitted by more than one mode, and, therefore, more than one additional precaution is needed. For example, a patient with suspected or confirmed Ebola virus disease (EVD) would be on contact and droplet precautions.
- Aerosol procedures: Aerosol-generating medical procedures (such as tracheostomy care, CPR, and nebulized therapy) may increase the risk of transmitting infectious agents. Airborne precautions may be initiated during specific procedures when a patient is suspected of having or confirmed to have TB.

Tables 7.4.1

, 7.4.2, and 7.4.3. summarize the three categories of additional precautions.

Table 7.4.1: Contact Precaution Guidelines

PPE	Private Room	Visitors	Patient Transport	Cleaning
Private room preferred for cohort patients. Must have own dedicated equipment.	Gown and gloves must be worn if providing direct care. Must perform hand hygiene before and after care. Must not go into other patient rooms.	Patient: none required Staff: gown and gloves	Additional daily room cleaning may be required.	
Data source: PIDAC, 2012; PHAC, 2013; Siegal, Rhinehart, Jackson, & HICPAC, 2007				

Table 7.4.2: Droplet Precautions

PPE	Private Room	Visitors	Patient Transport	Cleaning
Gloves, a gown, and a surgical mask if within two metres of the patient	Private room preferred or cohort. Must have own dedicated equipment.	Gowns, gloves, surgical masks, and eye protection are worn for all activities within two metres of the patient. The patient must wear a surgical mask when leaving the room. The door may remain open. Strict adherence to hand hygiene must be observed. Gloves, gown, and surgical mask must be worn if providing direct care. Must perform hand hygiene before and after care. Visitors may not go into other patient rooms.	Patient: gown, surgical mask	Additional daily room cleaning may be required.
Data source: PIDAC, 2012; PHAC, 2013; Siegal et al., 2007				

Table 7.4.3: Airborne Precautions

PPE	Private Room	Visitors	Patient Transport	Cleaning
Must wear an N95 respirator prior to entering the room. Strict adherence to hand hygiene. Must remove the N95 respirator after exiting the room. No immune-compromised persons to enter the room. Care providers should have current vaccines.	Yes. Must have a negative-pressure room. Must have own dedicated equipment. Keep the door closed, whether or not the patient is in the room. The room should have bathroom facilities. The room must be a single room, preferably one that is under negative pressure. When a negative pressure room is unavailable, refer to your health authority policy to determine whether a transfer to another facility is mandated.	Gloves, gown, and surgical mask required if providing direct care. Must perform hand hygiene before and after care. Must not go into other patient rooms.	Patient: must wear a surgical mask Staff: N95 mask	Additional daily room cleaning may be required.
Data source: PIDAC, 2012; PHAC, 2013; Siegal et al., 2007				

7.4.1 Contact Precautions

Contact precautions are the most common type of additional precautions. Contact precautions are used in

addition to routine practice for clients known or suspected to be infected with microorganisms that can be transferred by direct or indirect contact.

Direct contact occurs through touching a client. For example, when touching a client while assisting them with elimination or getting out of bed. Indirect contact occurs when touching a contaminated object or surface. For example, when auscultating a client's chest, the stethoscope directly touches the client and becomes contaminated. Subsequently, when the stethoscope touches you or another client, the microorganism is indirectly transmitted to another person.

Types of microorganisms in the contact category include antibiotic-resistant organisms (AROs) such as methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant *Enterococci* (VRE), extended spectrum beta-lactamase (ESBL), *C. difficile*, carbapenemase-producing organisms (CPO), agents of infectious diarrheas, and scabies. AROs are also known as multidrug-resistant organisms (MDROs).

Risk assessment for contact microorganisms includes:

- Hand hygiene: before, during, and after care as needed.
- Wear gloves and a gown when providing direct care.
- Follow routine practices for all care.
- The client should be in a private room if possible, and the door can remain open. If a private room is not possible, use a cohort room with clients with the same diagnosis. If in a cohort room, ensure each client has dedicated equipment and that the equipment is cleaned between uses.
- Clean the area daily and more frequently in high-touch areas. Special cleaning is required for VRE- and *C. difficile*-diagnosed clients.
- Is the proper contact/additional precaution sign on the door?



VISITORS

GET INSTRUCTIONS FROM
STAFF BEFORE ENTERING

CONTACT PRECAUTIONS

IN ADDITION TO ROUTINE PRACTICES

ACUTE CARE



Wear gloves



Wear long-sleeved gown



Dedicate equipment to patient or
disinfect before use with another

Public
Health
Ontario

PARTNERS FOR HEALTH

Santé
publique
Ontario

PARTENAIRES POUR LA SANTÉ



Ontario

Agency for Health
Protection and Promotion
Agence de protection et
de promotion de la santé

Image Description

The image is a Contact Precautions sign for acute-care settings. It instructs visitors to speak with staff before entering the room. In addition to Routine Practices, health-care providers and visitors must:

Wear gloves.

Wear a long-sleeved gown.

Dedicate equipment to the patient or disinfect it before using it with another patient.

The sign uses glove, gown, and medical-equipment icons to reinforce the required precautions. It was produced by Public Health Ontario and the Ontario Ministry of Health and Long-Term Care.



Contact Precaution Example

Slide the bar on the image to see the difference between a practitioner before and after exercising contact precaution interventions.

Text Description

This image-comparison activity shows the same health-care provider standing outside a client's room before and after preparing to follow contact precautions.

In the first image, the health-care provider is wearing navy scrubs and white shoes. She is not wearing gloves, a gown, or other additional personal protective equipment. The client's door does not display a contact precautions sign.

In the second image, the health-care provider is wearing disposable gloves and a long-sleeved isolation gown over her scrubs. A contact precautions sign is displayed on the client's door. The sign instructs visitors to speak with staff before entering and indicates that gloves and a long-sleeved gown must be worn. It also states that equipment should be dedicated to the client or disinfected before being used with another client. Routine Practices must also be followed as needed.

The main differences are the addition of appropriate personal protective equipment and the contact precautions sign identifying the measures required before entering the room.

To prevent the transmission of contact precaution microorganisms, it is important to follow routine practices and the additional precautions outlined in the following tables by Public Health Ontario (PIDAC, 2012). Note that interventions listed in the precaution tables are in addition to routine practices.

Table 7.4.4: Contact Precaution Interventions

Element	Acute Care	Complex Continuing Care/ Rehab	Long-term Care	Ambulatory/Clinic Setting	Home Health Care
Accommodation	The door may be open				No restrictions on accommodation
	Single room with a dedicated toilet and patient sink		Placement is on a case-by-case basis		
	Remain in the room unless required for diagnostic, therapeutic, or ambulation purposes	Not required to remain in the room unless symptomatic		Identify patients who require precautions	
	May go, or be taken, outside the facility, but cannot visit other patient rooms			Encourage the client to perform hand hygiene on entering the setting	
Signage	Yes			Flag chart	
Gloves	For all activities in the room/bed space		For direct care (see Glossary)		
Gown	For all activities where skin or clothing will come in contact with the patient or the patient's environment		For direct care (see Glossary)		

Table 7.4.5: Additional interventions by care setting

Element	Acute Care	Complex Continuing Care/ Rehab	Long-term Care	Ambulatory/ Clinic Setting	Home Health Care
Equipment and items in the environment	Dedicate if possible			As per Routine Practices	As per Routine Practices
	A chart (paper or mobile electronic) should not be taken into the patient/ resident environment.				
	Clean and disinfect shared care items.				
Environmental Cleaning	VRE and <i>C. difficile</i> rooms require special cleaning.				Routine household cleaning
	Routine cleaning for all other rooms.				
	Remove and launder all curtains (privacy and shower) when visibly soiled and during discharge/transfer cleaning.				
Transport	Staff wear gloves and a gown for direct contact with the patient during transport.		Staff wear appropriate PPE for direct contact with the resident during transport.	Not applicable	
	Clean and disinfect equipment used for transport after use.				
Communication	Effective precautions must be communicated to the client/patient/resident, families, other departments, other facilities, and transport services before transfer.				



Activity: Test Your Understanding

Answer the following questions to see how well you understand contact precautions.

Text Description

This three-part activity presents a case involving a client diagnosed with methicillin-resistant *Staphylococcus aureus* (MRSA) who is on contact precautions.

Part 1: Selecting personal protective equipment

The learner is asked:

The client has been diagnosed with MRSA. You need to assist the client to get dressed. What personal protective equipment is required when providing direct care? Select all that apply.

The answer choices are:

- Gloves
- Gown
- Mask
- Eye protection

Correct response: Gloves and a gown.

Gloves are required when providing direct care to a client on contact precautions. A gown is also required when the health-care provider's uniform or exposed skin may contact the client or the client's environment. This includes activities such as assessment, elimination care, dressing, mobility assistance, or contact with potentially contaminated surfaces such as bed rails and tables.

A mask and eye protection are not routinely required for contact precautions. However, they may be required under Routine Practices when the care being provided could produce splashes or sprays, such as during oral care.

An accompanying photograph shows a client lying in a hospital bed.

Part 2: Responding to the client's roommate

While providing care, the client's roommate asks the health-care provider to pass them their call bell.

Correct response: Before assisting the roommate, the health-care provider must remove their gloves and gown, perform hand hygiene, and put on new personal protective equipment as required. New personal protective equipment must be used for each client.

Part 3: Removing personal protective equipment

The learner places the following steps in the correct order for removing personal protective equipment:

1. Remove gloves.
2. Remove the gown.
3. Perform hand hygiene.

An accompanying photograph shows a health-care provider wearing gloves and a long-sleeved gown outside a room displaying a contact precautions sign. The sign indicates that gloves and a gown must be worn and that dedicated equipment should be used or disinfected before use with another client. Routine Practices must also be followed as needed.

Text Description

This three-part activity presents a case involving a client diagnosed with vancomycin-resistant enterococcus (VRE) who requires contact precautions.

Part 1: Delivering a meal tray

The learner is asked:

The client has been diagnosed with vancomycin-resistant enterococcus (VRE). You need to deliver the client their meal tray. What personal protective equipment is required when delivering a meal tray into the client's room?

The answer choices are:

- Gloves
- Gown
- Mask
- Eye protection
- N95 respirator

Correct response: Gloves.

Gloves are required when carrying the meal tray into the room and placing it on the client's table. A gown is not required when only delivering a food tray, performing a visual check, or speaking with the client without touching the client or the surrounding environment. VRE is transmitted through contact, so a mask, eye protection, and an N95 respirator are not routinely required. Additional personal protective equipment may be needed under Routine Practices depending on the care being provided.

An accompanying photograph shows a smiling client sitting upright in a hospital bed.

Part 2: Assisting the client to move in bed

After the meal tray has been delivered, the client asks for assistance moving up in the bed.

The answer choices are:

- Assist the client in moving up in the bed.
- Put on a gown before assisting the client.
- Remove the gloves, perform hand hygiene, and put on new personal protective equipment before assisting the client.
- Tell the client that assistance will be requested from another health-care provider.

Correct response: Remove the gloves, perform hand hygiene, and put on new personal protective equipment before assisting the client.

The gloves used while delivering the meal tray are considered contaminated. Before providing direct care, the health-care provider must remove the gloves, perform hand hygiene, and put on new personal protective equipment. A gown and gloves are required to assist the client with moving in bed.

Part 3: Environmental cleaning

The learner is asked:

What type of cleaning is required for this client and their surrounding environment?

Answer: VRE requires additional environmental cleaning procedures. When wiping a surface, a cloth should be used only once, and the appropriate disinfectants must be used. Visibly soiled linens must be removed and placed in the appropriate receptacle. All shared spaces and frequently touched surfaces must be cleaned thoroughly.

Text Description

This three-part activity presents a case involving a client who has been diagnosed with *Clostridioides difficile* (*C. difficile*) and requires contact precautions.

Part 1: Selecting appropriate accommodation

The learner is asked:

A client has recently been diagnosed with *C. difficile*. What type of accommodation should the client be in?

The answer choices are:

- Single room with the door open
- Cohort room with other clients on contact precautions
- Negative-air-pressure room with the door closed
- No special accommodation requirements

Correct response: A single room with the door open.

Ideally, the client should be placed in a single room. The door may remain open because *C. difficile* requires contact precautions rather than airborne precautions. When cohorting is necessary, clients must have the same microorganism; clients should not be grouped together simply because they are all receiving contact precautions.

An accompanying photograph shows a child sitting in a wheelchair and wearing a pink dress and tiara while holding a star-shaped wand. One foot is wrapped in a bandage.

Part 2: Responding to body-fluid exposure

While assisting the client with elimination, the client experiences uncontrolled diarrhea, and some of the stool comes into contact with a care partner's exposed wrist.

The learner is asked how the exposed area should be cleaned.

The answer choices are:

- Wipe off excess soil and wash the exposed area with soap and water
- Wipe off the excess soil with a towel and put on new personal protective equipment before continuing care
- Rinse the exposed area with water and perform hand hygiene using alcohol-based hand rub
- Remove the soiled personal protective equipment and put on new personal protective equipment before continuing care

Correct response: Wipe off excess soil and wash the exposed area with soap and water.

Because the client has *C. difficile*, the exposed wrist must be washed thoroughly with soap and water. The care partner should then remove and replace their gloves, wash their hands, and put on new gloves before continuing care.

Part 3: Selecting personal protective equipment

The client's care partner asks for assistance moving the client to the bathroom and helping with elimination.

The learner is asked:

What personal protective equipment is required when providing direct care? Select all that apply.

The answer choices are:

- Gloves
- Gown
- Mask
- Eye protection
- N95 respirator

Intended correct response: Gloves and a gown.

Gloves and a gown are required when providing direct care to a client on contact precautions. A mask and eye protection are not routinely required for contact precautions, but may be needed under Routine Practices when there is a risk of splashes or sprays. An N95 respirator is not required for contact precautions.

7.4.2 Droplet Precautions

Droplet precautions are used in addition to routine practices for clients who are known or suspected to be infected with microorganisms that are spread through the air by large droplets.

Types of microorganisms and unconfirmed conditions in this category include influenza, vomiting of unknown cause, mumps, pertussis, Group A *Streptococcus*, and unconfirmed cough.

Risk assessment for droplet microorganisms includes:

- Hand hygiene: before, during, and after care as needed.
- Wear a surgical mask and eye protection when providing direct care, or within 2 meters of the client. Follow routine practices (e.g., gown and gloves) as needed according to the care being provided.
- The client should be in a private room if possible, and the door can remain open as long as the client is positioned 2 meters away from the entry of the door. If a private room is not available, use a cohort room with clients with the same diagnosis. If using a cohort room, ensure each client has dedicated equipment and that the equipment is cleaned between uses.
- Clean the area daily and more frequently in high-touch areas.
- Post a droplet precaution sign on the door.



VISITORS

GET INSTRUCTIONS FROM
STAFF BEFORE ENTERING

DROPLET PRECAUTIONS

IN ADDITION TO ROUTINE PRACTICES
ACUTE CARE



**Wear mask and eye protection
within 2 metres of patient**



**Patient must wear a mask
if they leave the room**

Image Description

The image is a Droplet Precautions sign for acute-care settings. It instructs visitors to speak with staff before entering the room. In addition to Routine Practices, healthcare providers and visitors must wear a mask and eye protection when they are within two metres of the patient. The patient must wear a mask when leaving the room. The sign uses illustrations of masked faces and eye protection to reinforce the required precautions. It was produced by Public Health Ontario and the Ontario Ministry of Health and Long-Term Care.



Droplet Precaution Example

Slide the bar on the image to see the difference between a practitioner before and after exercising droplet precaution interventions.

Text Description

This image-comparison activity shows the same health-care provider standing outside a client's room before and after preparing to follow droplet precautions.

In the first image, the health-care provider is wearing navy scrubs without a mask or eye protection. No droplet precautions sign is displayed on the door.

In the second image, the health-care provider is wearing a medical mask and protective eyewear. A droplet precautions sign is displayed on the door, indicating that a mask and eye protection must be worn when within two metres of the client and that the client must wear a mask when leaving the room. Text beside the sign states that Routine Practices should also be followed as needed.

The main differences are the addition of a medical mask, protective eyewear, the droplet precautions sign, and the reminder to use Routine Practices as required.

To prevent the transmission of droplet precaution microorganisms, it is important to follow routine practices and the droplet precautions outlined in the following table by Public Health Ontario (PIDAC, 2012):

Table 7.4.6: Droplet Precaution Interventions

Element	Acute Care	Complex Continuing Care/ Rehab	Long-term Care	Ambulatory/ Clinic Setting	Home Health Care
Accommodation	The door may be open				Discuss the feasibility of spatial separation with the client (e.g., when sleeping)
	Single room with a dedicated toilet and patient sink preferred	Patient/resident to remain in room or bed space if feasible, or wear a mask (if tolerated) if coughing within two metres of other patients, until no longer infectious		Triage client/ patient away from the waiting area to a single room as soon as possible, or maintain a two-metre spatial separation	
	Cohorting of those who are confirmed to have the same infectious agent may be acceptable	Draw the privacy curtain		Patient to wear a mask for the duration of the visit and perform hand hygiene	
	Remain in the room unless required for diagnostic, therapeutic or ambulation purposes				
Signage	Yes				Not applicable
Facial Protection	Yes, within two metres of client/patient/resident				
Equipment and items in the environment	Dedicate if possible				
	A chart (paper or mobile electronic) should not be taken into the room				
Environmental Cleaning	Routine cleaning				
Transport	Client/patient/resident to wear a mask during transport				
	Limit transport unless required for diagnostic or therapeutic procedures				Not applicable
Communication	Effective precautions must be communicated to patient families, other departments, other facilities and transport services prior to transfer				

Read More

Routine Practices and Additional Precautions from Public Health Ontario



Activity: Test Your Understanding

Answer the following questions to see how well you understand droplet precautions.

Text Description

This four-part activity presents a case involving an adult client in an acute-care unit who has been diagnosed with meningitis and placed on droplet precautions.

Part 1: Selecting appropriate accommodation

The learner is asked:

What accommodation elements should be implemented for the client? Select all that apply.

The answer choices are:

- Single room
- Door open
- Cohort room with other clients on droplet precautions
- Negative-pressure room with the door closed
- Door closed
- Dedicated toilet and sink area
- Signage on the door indicating additional precautions

Correct responses:

- Single room
- Door open
- Dedicated toilet and sink area
- Signage on the door indicating additional precautions

A single room is preferred. When this is not possible, the client may share a room with other clients who have been confirmed to have the same infectious agent. Merely placing clients together because they are all on droplet precautions is not sufficient.

The door may remain open as long as the client's bed is at least two metres from the doorway. A negative-pressure room and a closed door are not required for droplet precautions. A dedicated toilet and sink area is preferred when clients share a room, and a droplet precautions sign must be displayed on the door.

Part 2: Selecting personal protective equipment

The learner is asked:

What PPE should the health-care provider wear before entering the client's room? Select all that apply.

The answer choices are:

- Gloves

- Gown
- Hair net
- Mask
- Eye protection
- N95 respirator
- Routine Practices

Correct responses:

- Mask
- Eye protection
- Routine Practices

The health-care provider must wear a medical mask and eye protection when working within two metres of the client. Routine Practices must also be followed according to the type of care being provided.

Gloves and a gown are not automatically required solely because the client is on droplet precautions. They should be worn when indicated by Routine Practices, such as when there is a risk of contact with body fluids or contamination of the provider's skin or clothing. A hair net and an N95 respirator are not routinely required for droplet precautions.

Part 3: Preparing the client for transport

The client must leave the room to be transported for an X-ray. The learner is asked:

What PPE and Routine Practices should the client use during transport? Select all that apply.

The answer choices are:

- Gloves
- Gown
- Hair net
- Mask
- Eye protection
- N95 respirator
- Hand hygiene

Correct responses:

- Mask
- Hand hygiene

The client must perform hand hygiene before leaving the room and wear a medical mask during transport. The client does not routinely need gloves, a gown, a hair net, eye protection, or an N95 respirator.

Part 4: Environmental cleaning

The learner responds to the following true-or-false statement:

The client has moved to another unit in the hospital. Special cleaning is required for meningitis.

Correct response: False.

Routine environmental cleaning is required after a client with meningitis leaves the room. Special

cleaning procedures are reserved for certain infectious agents, such as vancomycin-resistant enterococci and *Clostridioides difficile*.

7.4.3 Airborne Precautions

Airborne precautions are used in addition to routine practices for clients who are known to have or are suspected of having an illness that is transmitted by small droplet nuclei that may stay suspended in the air and be inhaled by others. These particles can remain infectious for a long period of time when spread through the air.

Types of organisms in this category include tuberculosis (TB), measles, chickenpox (varicella), disseminated zoster, and severe acute respiratory syndrome (SARS).

Risk assessment for airborne microorganisms includes:

- Strict adherence to hand hygiene. Hand hygiene: before, during, and after care as needed.
- An N95 respirator is required prior to entering the room. Must remove the N95 respirator after exiting the room.
- No immunocompromised persons can enter the room. Healthcare providers should know their vaccine status and have current vaccines.
- The client must have a negative-pressure room with their own dedicated equipment. The door needs to be kept closed whether or not the client is in the room. The room should have bathroom facilities and be a single room, preferably one that is under negative pressure. If a negative pressure room is unavailable, refer to your healthcare setting policies to determine whether a transfer to another facility is mandated.
- Clean the environment daily and more frequently in high-touch areas. Protocols related to negative pressure rooms must be followed.
- Is the proper airborne-additional precaution sign on the door?



VISITORS

GET INSTRUCTIONS FROM
STAFF BEFORE ENTERING

AIRBORNE PRECAUTIONS

IN ADDITION TO ROUTINE PRACTICES
ACUTE CARE



Keep door closed



Wear N95, fit tested and seal-checked respirator for TB

For measles, varicella, or disseminated zoster only
immune staff may enter and N95 is not required



Transport patient if necessary;
patient to wear a procedure mask for transport



Staff - wear an N95 respirator as per directions
above during transport

Image Description

The image is an Airborne Precautions sign for acute-care settings. It instructs visitors to speak with staff before entering the room. In addition to Routine Practices, the sign directs health-care providers to:

- Keep the patient's room door closed.
- Wear a fit-tested and seal-checked N95 respirator when caring for a patient with tuberculosis.
- For measles, varicella, or disseminated zoster, allow only immune staff to enter; an N95 respirator is not required for immune staff.
- Transport the patient only when necessary.
- Have the patient wear a procedure mask during transport.
- Have staff wear an N95 respirator during transport when required by the precautions above.

The sign was produced by Public Health Ontario and the Ontario Ministry of Health and Long-Term Care.



Airborne Precaution Example

Slide the bar on the image to see the difference between a practitioner before and after exercising airborne precaution interventions.

Text Description

This image-comparison activity shows the same health-care provider standing outside a client's room before and after preparing to follow airborne precautions.

In the first image, the health-care provider is wearing a navy uniform without respiratory protection. No airborne precautions sign or additional instructions are displayed on the door.

In the second image, the health-care provider is wearing an N95 respirator. An airborne precautions sign is displayed on the closed door. The sign indicates that the door must remain closed and provides instructions about respiratory protection and transporting the client. Text below the sign states that Routine Practices must also be followed as needed.

The main differences are the addition of the N95 respirator, the airborne precautions sign, and the reminder to follow Routine Practices.

Points of Consideration

Negative Pressure Rooms

A negative-pressure room is constructed with a special ventilation design that restricts and limits the spread of airborne microorganisms from the client's room to the surrounding unit and healthcare setting through a pressurized system. The air pressure inside the room is lower than the air pressure outside the room. Due to this pressure system, which needs to be monitored, when the door opens, the airborne microorganisms in the room will not flow outside of the room and into the surrounding environment. Instead, the airborne microorganisms are sucked into a specialized engineered exhaust system that filters the air (e.g., with HEPA filters) before it is pushed outside of the healthcare facility (PIDAC, 2018).

When providing care to clients on airborne precautions, the door of a negative-pressure room should always be closed to maintain the lower pressure inside the room. Some negative pressure rooms have an anteroom, which is a smaller entry room attached to the negative pressure room for healthcare providers to put on and remove PPE prior to entering the client's room or prior to entering the healthcare unit. Review and follow the healthcare facility policies regarding negative pressure rooms and guidelines for airborne precautions.

If a healthcare facility does not have a negative pressure room, it is recommended that the client be moved to a single room and should wear a mask at all times, if capable. However, some healthcare settings cohort clients with COVID-19 depending on room availability and client presentation. Clients do not need to wear an N95 mask. When possible, the client should be moved to another facility that has a negative-pressure room available. (PIDAC, 2012).

To prevent the transmission of airborne-precaution microorganisms, it is important to follow routine practices and the additional precautions outlined in the following table by Public Health Ontario (PIDAC, 2012):

Table 7.4.7: Droplet Precaution Interventions

Element	Acute Care	Complex Continuing Care/ Rehab	Long-term Care	Ambulatory/ Clinic Setting	Home Health Care
Accommodation	Either an airborne infection isolation room or transfer			Airborne infection isolation room, if available, or alternate arrangements if necessary	Not applicable
Signage	Yes				Not applicable
N95 Respirator	TB	For entry to the room		For the duration of the visit	For entry to the client's home
	Measles, Varicella	Only immune staff to enter the room. N95 respirator not required if immune.			
Equipment and items in the environment	As per Routine Practices				
Environmental Cleaning	Routine cleaning				Routine household cleaning
Transport	Client/patient/resident to wear a mask during transport				Not applicable
	Transport staff to wear an N95 respirator during transport				
	Limit transport unless required for diagnostic or therapeutic procedures				
Communication	Effective precautions must be communicated to patient families, other departments, other facilities and transport services prior to transfer				



Activity: Test Your Understanding

Answer the following questions to see how well you understand airborne precautions.

Text Description

This three-part activity presents a case involving a client who has been admitted with measles. The client has a fever, dry cough, runny nose, and a large, flat, blotchy rash on the torso. The activity asks learners to apply airborne precautions.

Part 1: Selecting appropriate accommodation

The learner selects all appropriate accommodation measures for the client.

The answer choices are:

- Single room
- Door open
- Cohort room with other clients diagnosed with measles
- Negative-pressure room with the door closed
- Door closed
- Signage on the door indicating additional precautions

Correct responses:

- Single room
- Negative-pressure room with the door closed
- Door closed
- Signage on the door indicating additional precautions

A client with measles requires a single airborne infection isolation room with negative air pressure. The door must remain closed, and an airborne precautions sign must be displayed outside the room.

Part 2: Determining who may enter the room

The learner responds to the following true-or-false statement:

Health-care providers and visitors must be immune prior to entering the client's room.

Correct response: True.

Health-care providers and visitors who are not immune should not enter the negative-pressure room of a client diagnosed with measles.

Part 3: Preparing the client for transport

The client needs to be transported for a chest X-ray. The learner is asked what personal protective equipment the client should wear during transport.

The answer choices are:

- Gloves

- Gown
- Mask
- Eye protection
- N95 respirator

Correct response: Mask.

A client on airborne precautions must wear a medical or procedure mask while being transported. The client does not routinely need gloves, a gown, eye protection, or an N95 respirator during transport.

7.4.4 Combination of Additional Precautions

Some microorganisms have more than one mode of transmission; therefore, a combination of additional precautions must be followed. Prior to care, perform a point-of-care risk assessment. Review the client's diagnosis, reflect on your immunization status, determine the type of care that will be performed, and then assess what additional precautions are required.

For example, influenza, which is a respiratory virus, requires droplet precautions. However, if those droplets are secreted directly or indirectly on inanimate objects like the client's bed rails or call bell, then the virus can be transmitted through contact, which requires you to follow additional contact precautions depending on the care you will be providing the client.



VISITORS

GET INSTRUCTIONS FROM
STAFF BEFORE ENTERING

DROPLET CONTACT PRECAUTIONS

IN ADDITION TO ROUTINE PRACTICES
ACUTE CARE



Wear mask and eye protection
within 2 metres of patient



Wear gloves



Wear long-sleeved gown



Patient must wear a mask
if they leave the room



Dedicate equipment to patient or
disinfect before use with another

Image Description

The image is a Droplet Contact Precautions sign for acute-care settings. It instructs visitors to speak with staff before entering the room. In addition to Routine Practices, health-care providers and visitors must:

Wear a medical mask and eye protection when within two metres of the patient.

Wear gloves.

Wear a long-sleeved gown.

Have the patient wear a mask when leaving the room.

Dedicate equipment to the patient or disinfect it before using it with another patient.

The sign uses illustrations of a mask and eye protection, gloves, a gown, a masked patient, and medical equipment to reinforce the required precautions. It was produced by Public Health Ontario and the Ontario government.



Precautionary Interventions: Before and After Example

Slide the bar on the image to see the difference between a practitioner before and after exercising a combination of precautionary interventions.

Text Description

This image-comparison activity shows the same health-care provider standing outside a client's room before and after preparing to follow droplet and contact precautions.

In the first image, the health-care provider is wearing navy scrubs without a mask, protective eyewear, gown, or other additional personal protective equipment. No precautions sign is displayed on the door.

In the second image, the health-care provider is wearing a medical mask, protective eyewear, and a long-sleeved isolation gown over the scrubs. A droplet contact precautions sign is displayed on the door. The sign indicates that a mask and eye protection must be worn within two metres of the client, and that gloves and a long-sleeved gown are required for direct care. It also states that the client should wear a mask when leaving the room and that equipment should be dedicated or disinfected before use with another client. Text beside the sign reminds viewers to follow Routine Practices as needed.

The main differences are the addition of a medical mask, protective eyewear, an isolation gown, the droplet contact precautions sign, and the reminder to use Routine Practices.

Another example would be if a child were diagnosed with chickenpox, which is caused by the varicella-zoster virus; then airborne precautions would be followed. However, if the child begins to itch and scratch the fluid-filled blistering rash, the virus can be transmitted through direct contact. Therefore, the child should be in a

negative pressure room, with the door closed, with only immunized staff able to enter and wearing an N95 regulator mask, gown, and gloves.

Depending on the care provider for the client, the additional precautions may vary. For example, clients on bilevel positive airway pressure (BiPAP) overnight may have airborne precautions overnight, though they may have droplet or no precautions throughout the day.



Watch: Digital Story with Michael Nguyen

Video: "Infection Prevention and Control in Long Term Care" by Caitlin Cosgrove [25:29] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

7.4.5 COVID-19

COVID-19, also known as SARS-CoV-2, is a highly contagious virus and a serious health threat to individuals. Healthcare providers must be vigilant in infection prevention and control practices to decrease the risk of transmission of COVID-19 and increase safety during client care.

COVID-19 spreads through respiratory droplets and aerosols when an infected person coughs, sneezes, talks, or laughs, and during various medical procedures. The mode of transmission can be contact (direct or indirect), droplet, or airborne. Infectiousness with each mode is still unclear and is continuously being tested by scientists through research. The virus droplets can be large, which land shortly after exiting the respiratory system; for example, when talking, coughing, or sneezing. Or the virus can be smaller, which can linger and travel in the air, for example, during aerosol medical procedures. COVID-19 is a new virus, and scientists are continuously learning about the microorganism. It is important to continuously educate yourself, as well as clients, about the changing protocols and requirements needed to maintain safety and decrease the risk of transmission.



Image: "Corona Test Pandemic" by Hermann Kollinger, Pixabay License.

Watch the following video, *Virtual PPE Orientation*, to learn about the new COVID-19 precautions and information since the beginning of the pandemic. Remember, information is continuously changing and being updated, so you must maintain competency in your knowledge.



Watch: Digital Story with Michael Nguyen

Video: “VIRTUAL PPE ORIENTATION – Part 1: The New Normal” by University of Toronto PGME [10:44] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

The risk of contracting COVID-19 varies according to where you live, the client’s presenting symptoms, PPE resources available, health literacy, and human behaviours following infection prevention and control practices. As healthcare providers, knowing the mode of transmission will assist when performing a point-of-care risk assessment.

COVID-19 symptoms vary between people and may take up to 14 days to appear after exposure. People with COVID-19 can be asymptomatic or symptomatic.

COVID-19 Symptoms

Common COVID-19 symptoms can include:

- Temperature equal to or over 37.8°C.
- New or worsening cough.
- Shortness of breath or difficulty breathing.
- Sore throat, runny or congested nose.
- Difficulty swallowing.
- Changes in or loss of smell or taste.
- Gastrointestinal symptoms, including abdominal pain, diarrhea, nausea, and vomiting.

(Government of Canada, 2020a; Ontario Ministry of Health, 2020)

Atypical COVID-19 symptoms can include (particularly in infants, children, older persons, and people living with a developmental disability):

- Chills.
- Fatigue or weakness.
- Muscle or body aches.
- Pink eye.
- Headache.
- Feeling very unwell.
- Children tend to feel sluggish, have abdominal symptoms, lack of appetite and skin changes or rashes.

(Government of Canada, 2020a; Ontario Ministry of Health, 2020)

The older adult population, people living with a developmental disability, pregnant individuals, people with chronic illnesses, people who are immunocompromised, and people living with obesity are at greater risk of serious illness related to COVID-19.

To decrease your risk of contracting or transmitting COVID-19 in the healthcare setting, it is essential to maintain competency in the ever-changing information and to follow required routine practices and additional precautions related to the care that will be provided. (Government of Canada, 2020a; Ontario Ministry of Health, 2020).



Image: "Couple wearing face masks" by Tima Miroshnichenko, Pexels License.

Decrease Your Risk of Contracting or Transmitting COVID-19:

- Wear a mask when in public or when in close contact with others.
- Keep 2 meters apart from other individuals outside of your household.
- Wash your hands often with soap and water for a minimum of 20 seconds.
- Avoid touching your face with unwashed hands.
- Avoid closed and crowded places.
- Avoid areas with poor ventilation (re-circulated air).
- Avoid close contact with others. For example, when talking.
- Weather permitting, keep windows open or open periodically to decrease the concentration of aerosols inside.



Image: "Female in Medical Mask on Street" by RF...studio, Pexels License.

Routine Practices and Additional Precautions

Since COVID-19, the new protocol for routine practices includes a combination of additional precautions: droplet precautions (mask and eye protection) and contact precautions (mask and gloves), because clients who are asymptomatic and pre-symptomatic can transmit infection. When performing an aerosolized procedure (e.g., intubation, high flow nasal oxygen, suctioning a tracheostomy) on COVID-19 clients, airborne precautions such as an N95 respirator should be used, and a negative pressure room is recommended (PIDAC, 2012; Public Health Ontario, 2021).

Protocols regarding PPE have changed since the COVID-19 pandemic. Public Health Ontario (2021) provides updated guidelines to inform healthcare providers of the minimum expectations regarding PPE. The guidelines address PPE for inpatient facilities, ambulatory and outpatient facilities, and other settings, which include long-term care (Public Health Ontario, 2021). Healthcare providers need to refer to and follow the PPE protocols specific to their healthcare setting. Infection prevention and control protocols are specific to the type of care you provide to a client diagnosed with COVID-19 and according to your healthcare setting. Protocols can vary

between sites, units within each site, and the care being provided to the client. COVID-19 protocols are continuously changing according to new discoveries related to COVID-19 and according to PPE availability. It is important to stay up to date on current findings to ensure the safety of yourself and others.

For COVID-19 units, visual cues and a “buddy system” may be used.

- Visual aids help healthcare providers to remember the required steps, how to prevent self-contamination, and decrease the risk of transmission.
- The buddy system can help reduce the risk of contamination when removing PPE. Each healthcare provider watches their buddy as they remove their PPE. The healthcare providers are responsible for ensuring the PPE is removed safely during the procedure, stopping the other healthcare provider before a potential mistake occurs in the removal technique, and redirecting their buddy’s technique before continuing the removal of PPE.

Remember, it is not about shame or blame; instead, it is about safety. Removing PPE is when the highest risk for transmission occurs.



Watch: Digital Story with Michael Nguyen

Watch the following video, Keeping Yourself Safe During the COVID-19 Pandemic, Making the Best Use of PPE, to learn more about PPE and the steps involved when performing the ‘buddy system’.

Video: “KEEPING YOURSELF SAFE DURING THE COVID-19 PANDEMIC – Making the best use of PPE” by University of Toronto PGME [5:32] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Accommodation

Clients diagnosed with COVID-19 should be in a private room or cohort room with another client diagnosed with COVID-19 (Public Health Ontario, 2021). Cohorting healthcare providers should be dedicated and assigned to suspected or confirmed COVID-19 clients only to avoid transmission of the infection to non-suspected or COVID-19-negative clients (Public Health Ontario, 2021). It is recommended to use dedicated break times and areas for COVID healthcare providers within the healthcare setting.

Points of Consideration

COVID-19 Variants

COVID-19 is caused by the SARS-CoV-2 virus. COVID-19 was classified as a pandemic in March 2020. Since the beginning of the COVID-19 pandemic, various variants of the virus have emerged and evolved as the virus is continuously changing.

COVID-19 variants of concern that have emerged in Canada and are on the rise include B.1.1.7, which was first identified in the United Kingdom, B.1.351, which was first identified in South Africa, and P.1, which was first identified in Brazil (Government of Canada, 2021; Public Health Ontario, 2021).

Scientists are continuously seeking out and assessing new variants to determine how the virus is changing, how the variant is transmitted, the variant's effect on humans, the severity of the virus, and the effectiveness of the vaccines on the new variants. It is important for you to stay up to date and informed about the continuously changing and new information about COVID-19. As new findings emerge, infection prevention and control practices may change or adapt to address the new findings of COVID-19 and the variant viruses.

Healthcare providers need to continually promote and educate the public about the importance of hand hygiene, maintaining physical distancing (e.g., 2 meters) with people outside of their household, avoiding crowded spaces and close contact, wearing a mask that covers the nose and goes under the chin, and cleaning their hands often.

Visitors

Currently, visitors are not allowed to physically visit someone diagnosed with COVID-19 when in the hospital. Instead, clients are encouraged to call or video call family and friends, if possible, to connect with them. In the healthcare setting, infection prevention and control practices related to COVID-19 protocols must be followed.

Client Transportation

The client's health status, use of medical equipment (e.g., aerosol) and where the client is being transported to and from, will determine which additional precautions to follow. One or a combination of the three additional precautions (contact, droplet and airborne) may be required (PIDAC, 2012).

Cleaning the Environment

COVID-19 can survive on surfaces from hours to days (depending on the surface and environment) if not cleaned properly (Government of Canada, 2020b; Public Health Ontario, 2021). High-touch surface areas should be cleaned and disinfected according to your healthcare facility's environmental service protocol (e.g., at least twice per day and when visibly soiled). The COVID-19 virus can travel via aerosol; therefore, cleaning and disinfecting equipment that uses aerosol and spray bottles should not be used to prevent the transmission of COVID-19 (Public Health Ontario, 2021).

Cohort environmental service staff should be assigned to COVID-19 clients or units if possible. Your healthcare facility should identify a plan for healthcare providers to follow. Where you work, and the status of the client,

will determine how frequently cleaning should take place, the disinfectant contact time, and what cleaning and disinfectant materials should be used. Cleaning and disinfectant materials should be healthcare-grade with a drug identification number (DIN).

Link to Learning

To learn more about cleaning and disinfecting the environment for COVID-19, review the Government of Canada resource *COVID-19: Cleaning and disinfecting*.

Note

: Current guidelines are continuously changing as scientists learn more about COVID-19.

Psychosocial Factors

The impact of COVID-19 has been stressful for clients, their care partners, and their families. People in the community are also feeling helpless, lonely, and depressed from physical distancing. These responses are normal in a crisis. Healthcare providers can support clients by talking about their fears, clarifying any myths, and educating clients about the most current data on COVID-19.

Healthcare providers are also feeling stressed, uncertain, worried for their own safety, and are experiencing fatigue (Lapum et al., 2020). Further interventions are needed to support healthcare providers' emotional well-being during this pandemic, and continued support will be needed afterwards to address post-pandemic impacts. Remember to check in with your colleagues, as well as yourself, to assess your emotional well-being because it is essential to maintaining your mental health.

Tips for Taking Care of Yourself Include:

- Acknowledge that you are stressed and remember everyone feels stress at times.
- Reach out to family and friends by calling, video chats, or through social platforms to keep connected. It is important to engage with others.
- Practice mindfulness through deep breathing exercises, meditation, and stretching.
- Stay healthy by eating nutritious meals, exercising daily, and getting rest and sleep.
- Keep up to date on new information and follow COVID-19 infection prevention and control protocols.
- Be kind and patient because everyone handles crises differently.
- Be supportive of your family, friends, and community and accept support when you need it.



Image: "Untitled" by Gustavo Fring, Pexels License.



Activity: Test Your Understanding

Text Description

This four-part activity presents an emergency involving a client diagnosed with COVID-19 who is found unresponsive on the floor of a negative-pressure room. Learners apply infection-control measures while responding to a code blue.

Part 1: Identifying the priority action

The learner is asked:

A health-care provider finds a client diagnosed with COVID-19 unresponsive on the floor of their negative-pressure room. What is the priority action?

The answer choices are:

- Activate code blue.
- Begin CPR.
- Move the client onto the bed.
- Begin putting on personal protective equipment before entering the room.

Correct response: Activate code blue.

The activity explains that initiating a code blue is the priority response because it immediately calls for emergency assistance while supporting the safety of the client and the health-care provider.

An accompanying photograph shows an unresponsive client lying in a hospital bed while two health-care providers wearing full protective clothing, masks, face protection, and gloves provide respiratory assistance. A bedside monitor displays the client's vital signs.

Part 2: Putting on personal protective equipment

After the code blue is activated, the first responder puts on the appropriate personal protective equipment and enters the room. A second responder arrives and must also put on personal protective equipment.

The learner is asked:

Where should the second responder put on their personal protective equipment?

The answer choices are:

- Inside the negative-pressure room.
- Outside the negative-pressure room.

Correct response: Outside the negative-pressure room.

The activity explains that appropriate personal protective equipment must be put on before entering the anteroom and negative-pressure room. This helps reduce the risk of COVID-19 transmission by interrupting the chain of infection at the portal of entry.

Part 3: Positioning the code blue cart

The learner responds to the following true-or-false statement:

The third responder arrives with the code blue cart. The responder should bring the code blue cart into the room.

Correct response: False.

The activity explains that the code blue cart should remain outside the client's room to reduce the risk of contaminating the cart and transmitting COVID-19.

Part 4: Reviewing the emergency response

The final section is a reflection card. It notes that health-care institutions may have specific guidelines for responding to a code blue involving a client with COVID-19.

The learner is asked to reflect on institutional policies for the arrival of a code blue team at the client's room.

The reverse of the card lists the following suggested actions:

- Do not rush into the room.
- Put on the appropriate personal protective equipment and enter the room individually with the equipment required to support resuscitation.
- Brief the team and assign roles and responsibilities.
- Place the client on monitors inside the room.
- Leave the code blue cart in the hallway.
- Move the required medication into the anteroom.
- Follow protected-intubation guidelines.

7.4.6 Isolation and Client Care

When a client is in isolation, it can have a negative impact on the quality of care they receive from the health-care team. It takes extra time to put on and remove PPE, which may hinder healthcare providers' ability to assess or visit the client frequently in comparison to a client not in isolation. Healthcare providers should not assess the client from the door. Instead, it is important to take the time to put on PPE so you can go into the client's room safely and check in on how they are feeling.

Family and friends may also decrease or limit their visits due to fear of being infected. It is the healthcare provider's role to educate family and friends, thereby decreasing any fears or myths related to transmission. If visitors are unable to visit the client, find alternative methods to ensure the client does not experience loneliness or depression.

For example, connect the client with their family or friends over the phone, or on social media, or through live discussions via the internet. An alternative option is to request a volunteer, who is trained in infection prevention and control practices, to visit the client and provide psychosocial support through talking or activities.

Some clients may experience anxiety, depression, or sleep disturbance (PIDAC, 2012). Monitor for these signs and assist the client in finding appropriate supports. Structuring activities or visits can help decrease the risk.

Another intervention is to continuously monitor the client's symptoms and remove the additional precautions once it is safe and no longer required. Through effective interprofessional communication and documentation, the healthcare team can maintain focus on the client.



Link to Learning

Additional Precautions Signage and Lanyard Cards

From Theory to Practice

In each of the following pictures, the healthcare provider (HCP) has contaminated themselves. It's your job to find the spots where the potential contamination has occurred. Good luck and destroy those microorganisms!

Text Description

This activity shows a health-care provider standing at a sink with running water. The provider is wearing navy scrubs, has long dark hair tied in a loose ponytail, and is wearing a wristwatch. The learner is instructed:

The healthcare provider has contaminated their hands. Find the six hot spots where contamination has occurred.

The six areas of concern are:

1. Hair hanging down the provider's back: Long strands extend below the shoulders. Hair should be securely tied up and kept off the shoulders to reduce the risk of contamination.
2. Hair hanging over the front of the uniform: Loose strands fall forward near the provider's clothing and work area. Hair should be fully secured and kept away from the uniform.
3. Wristwatch: The watch is positioned close to the provider's wrist and hands. It should be moved above the wrist or removed so that it does not interfere with effective hand hygiene or become contaminated.
4. Uniform touching the sink: The provider is leaning against the sink, which may contaminate the uniform.
5. Arm resting on the sink: The provider's forearm is touching the sink surface, creating another opportunity for contamination.
6. Long artificial fingernails: The provider's fingernails are artificial and long. Fingernails should be kept short and free of artificial nails and nail polish.

Text Description

This activity shows a health-care provider standing in a clinical room beside a yellow isolation and personal protective equipment cart. The provider is wearing a medical mask, gloves, and a disposable isolation gown. The learner is instructed:

The microorganisms have taken over this health-care provider! Find the hot spots where the invasions have occurred.

The activity contains five areas where the personal protective equipment is being worn incorrectly:

1. Hair resting on the gown: The provider's long hair is hanging over the shoulder and touching the potentially contaminated gown. Long hair should be tied up and kept off the shoulders.
2. Gloves are too large: The gloves do not fit the provider's hands properly. Gloves should fit securely and should be neither too loose nor too small and tight.
3. Exposed wrist and watch: The gown sleeves are too short and are not tucked into the gloves,

leaving the provider's wrist and watch exposed. The gown sleeves should extend into the gloves to reduce the risk of contamination.

4. Gown is loose: The gown is not tied securely around the neck or waist and does not fully cover the provider's clothing and watch. The gown should fit securely and provide adequate coverage.
5. Mask is not secured around the nose: The upper edge of the mask has not been pinched and shaped around the bridge of the nose. The mask should be fitted securely around the nose to reduce gaps.

Text Description

This activity shows a healthcare provider's hands wearing transparent, non-sterile gloves. The learner is instructed:

Find the hot spots on the health-care provider's gloved hands where there is an increased risk of contamination.

The activity contains four areas of concern:

1. Wristwatch worn beneath the glove: The provider is wearing a watch under the glove at the wrist. The watch should be removed before putting on gloves because it can interfere with proper glove fit and increase the risk of contamination.
2. Glove cuff folded inward: The cuff of one glove is tucked or rolled inward rather than lying flat against the wrist. This can interfere with coverage and increase the risk of contamination.
3. Fingernails are too long: The provider's long fingernails may puncture the gloves and create an opening through which contamination can occur.
4. Gloves are too tight: The gloves fit too tightly around the hands and fingers. Gloves that are too small may tear during use, increasing the risk of exposure and contamination.

Text Description

This activity shows a health-care provider rubbing their hands together beside a yellow clinical supply cart. The learner is instructed:

Find the hot spots on the healthcare provider's hands where microorganisms can live.

The activity contains four areas of concern:

1. Hair band around the wrist: The provider is wearing a hair band around the wrist. Wrists should be free of hair bands, bracelets, watches, and other items when performing hand hygiene because these objects can interfere with cleaning and harbour microorganisms.
2. Visible soiling near the fingernail: There is visible soiling along the side of the provider's little fingernail and near the nail. When hands are visibly soiled, they must be washed with soap and water rather than cleaned only with alcohol-based hand rub.
3. Long artificial fingernails on one hand: The provider is wearing long artificial fingernails, which can harbour microorganisms. Fingernails should be kept short and free of artificial nail products and nail polish.
4. Long artificial fingernails on the other hand: Additional long artificial fingernails are visible on the provider's other hand, creating the same increased risk of microorganisms remaining beneath or around the nails.

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The 7.4.1-7.4.6 sections are adapted from “Contact Precautions”, “Droplet Precautions”, “Airborne Precautions”, “Combination of Additional Precautions”, “COVID-19”, “Isolation in Client Care” in *Introduction to Infection Prevention and Control Practices for the Interprofessional Learner* Copyright © by Michelle Hughes; Audrey Kenmir; Oona St-Amant; Caitlin Cosgrove; and Grace Sharpe, which is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, except where otherwise noted.

The *From Theory to Practice* section is adapted from “What’s Wrong With this Picture?” in *Infection Prevention and Control Practices*, Copyright © 2019 by Michelle Hughes and Kendra Allen, which is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

7.5 Personal Protective Equipment (PPE)

Personal Protective Equipment (PPE)

Additional precautions require the use of *personal protective equipment (PPE)*, which is equipment or clothing worn by staff to prevent the transmission of infection from patient to staff or to family members (PIDAC, 2012). All PPE must be applied and removed in a specific order to ensure the skin, nose, mouth, and eyes are covered to prevent transmission of infection to health care providers. Depending on the type of additional precaution or risk assessment, a gown, goggles, face shield, and mask (surgical or N95) may be used during patient care.

Refer to Table 7.5.1 for steps to take when donning (putting on) PPE.

Table 7.5.1: Donning PPE

Disclaimer: Always review and follow your hospital policy regarding this specific skill.	
Safety considerations: • The selection of PPE is based on the nature of the interaction with the patient and the likelihood of transmission of infectious agents. • PPE should be put on just prior to the interaction with the patient and should be removed immediately after the interaction, followed by hand hygiene. • Patients may feel depressed or lonely when isolated in a room or experiencing decreased contact with health care providers. Support for individuals on isolation must be provided. Conversely, some patients may appreciate the privacy of an individual room.	
Steps	Additional Information
1. Remove rings, bracelets, and watches. Perform hand hygiene.	This prepares hands for direct patient care.  <i>Perform hand hygiene</i>
2. Apply waterproof long-sleeved gown. Tie the neck and waist strings.	Waterproof gown prevents any potential cross-contamination from blood or body fluids onto forearms and body.  <i>Apply waterproof gown</i>

3. Apply surgical or N95 mask. Ensure the fit is secure with no air leaks. Secure the metal band around the nose and pull mask over chin as required.	Wearing a poor-fitting mask is the number one reason for exposure to pathogens for health care providers. Masks should be worn if the provider is within two metres of a coughing or sneezing patient or if there is a potential for spray of secretions or excretions.  <i>Surgical mask (left) and N95 mask (right)</i> Replace mask if it becomes wet or soiled.  <i>Apply mask</i>
4. Apply goggles or face shield.	Goggles or a face shield prevents accidental exposure to eyes, nose, and mouth. Goggles can be placed on top of eyeglasses. Prescription glasses are not an alternative to goggles as they do not protect the entire eye.  <i>Apply goggles</i>

5. Apply non-sterile gloves over top of the cuff of the gown.	Non-sterile gloves ensure complete coverage of skin on arms for direct patient care.  <i>Apply non-sterile gloves over top of sleeves</i>
Data source: Barratt, Shaban, & Moyle, 2011; PIDAC, 2012; PHAC, 2012b	

See Table 7.5.2 for steps on how to doff (remove) PPE.

Table 7.5.2: Doffing PPE

Disclaimer: Always review and follow your hospital policy regarding this specific skill.	
Steps	Additional Information
1. Remove gloves.	Grasp outer edge of glove by wrist and peel away from hand, rolling the glove inside out. Roll it into a ball in gloved hand. With the bare hand, reach under the second glove and gently peel down off the fingers.  <i>Place bare finger under glove to avoid contamination from glove</i> Drop glove into garbage bin. Always perform hand hygiene after removing gloves. Gloves are not tear- or leak-proof. Hands may have been contaminated upon removal of the gloves.
2. Perform hand hygiene.	Clean hands if they feel or look dirty.  <i>Perform hand hygiene</i>

3. Remove gown.	Remove gown in a manner that does not contaminate clothing. Starting at the neck ties, pull the outer (contaminated) part forward and, turned inward, roll into a ball. Discard in appropriate receptacle bin.  <i>Remove gown</i>
4. Perform hand hygiene.	Always perform hand hygiene after removing gown. Hands may have been contaminated upon removal of the gown.  <i>Perform hand hygiene</i>
5. Remove eye protection or face shield.	Arms of goggles and the headband on the face shield are considered clean. Handle these only by the sides. The front of the face shield or goggles is considered contaminated. Dispose them according to agency policy.  <i>Remove goggles</i>

6. Remove mask/N95 respirator.	Ties, earlobe loops, or straps are considered clean and may be touched. If tied, remove the bottom tie first, then the top tie. Remove ear loops or straps by leaning forward to allow the mask to slip off your face. Dispose of the mask in the garbage bin.  <i>Remove mask</i>
7. Perform hand hygiene.	This step reduces the transmission of microorganisms.  <i>Perform hand hygiene</i>
Data source: Barratt et al., 2011; Perry et al., 2014; PHAC, 2012b; Siegal et al., 2007	



Video: Donning and Doffing PPE

Video: “Donning and Doffing” by Renée Anderson & Wendy McKenzie [7:29] is licensed under a Creative Commons 4.0 International License. *Transcript available [PDF].*

Blood or Body Fluid (BBF) Exposure

A *blood and body fluid (BBF) exposure* is defined as an exposure to potentially infectious body fluids or blood through the following methods: a puncture wound by a sharp object or needle (percutaneous exposure), from a body fluid/blood splash onto your mucous membranes (permucosal exposure) or exposure through eczema, an open wound/skin or scratch (non-intact skin exposure) (BCCDC, 2015).

Post-exposure management is only required when (1) percutaneous, permucosal, or non-intact skin is exposed to a BBF; (2) the exposure is to blood or potentially infectious body tissue or fluid; (3) the source is considered potentially infectious (e.g., patient is part of a high-risk group, exposure occurred in a high-risk setting, or patient has a positive test); and (4) the exposed person is considered susceptible to HIV, hepatitis B, or hepatitis C.

Table 7.5.3 explains what to do if exposed.

Table 7.5.3: BBF Exposure

Disclaimer: Always review and follow your hospital policy regarding this specific skill.	
Safety considerations: • Evidence shows that antiretroviral therapy can reduce the transmission of HIV by 86%. • The risks and benefits of the post-exposure immunoprophylaxis should be discussed, and appropriate recommendations should be made by the physician to the exposed person. • Despite the relatively low risk of infection from an exposure, the event is associated with stress and anxiety for the exposed person. • Seek advice from a physician at a hospital, walk-in clinic, or community clinic within two hours of any BBF exposure. • Not all body fluids are implicated in the transmission of viruses. Review the CDC guidelines [PDF] to understand which body fluids are implicated in transmitting HIV and hepatitis B and C.	
Steps	Additional Information
1. Wash the exposed skin, mucous membrane, or eye.	Skin: Wash the area thoroughly with soap and water. Mucous membranes or eye: Rinse the area with water or normal saline. Allow the injury/wound site to bleed freely and then cover lightly. Do not promote bleeding of percutaneous injuries by cutting, scratching, or squeezing or puncturing the skin. This may damage the skin and increase uptake of any pathogens. Do not apply bleach or soak the wound/injury in bleach.
2. Contact first aid for assistance and obtain proper forms. These forms are also available in emergency departments.	If unable to contact first aid, proceed to the emergency room.
3. Advise your supervisor or charge nurse of the incident. Ask them to complete the required form and return it to you.	This step allows for follow-up by the manager in relation to a BBF exposure.
4. A risk assessment should be completed within two hours. Go to the emergency room or urgent care centre and be assessed by a physician/NP. Inform the department personnel that an occupational BBF exposure has occurred. You will be assessed, and blood work will be drawn.	Emergency rooms or other health agencies are supplied with antiretroviral kits from the BC Centre for Excellence in HIV/AIDS. Physicians will assess your risk of exposure and the risk of transmission from the source.
5. Following treatment, return to your department and report the incident according to agency policy.	This ensures that the proper procedure is followed and the incident form is filled out to prevent or minimize further exposure.
Data source: BCCDC, 2015	



Activity: Critical Thinking Exercises

1. A family member has come into the health care setting to visit his mother, who has been admitted with chicken pox. List four infection preventive measures to discuss with the family member.
2. How is PPE selected for patient care?

From Theory to Practice

Personal Protective Equipment Interactive Videos

In these interactive videos, you will have the opportunity to test your knowledge on donning and removing personal protective equipment (PPE). As you watch the interactive videos, you will be asked questions throughout the performance of the skill. You must answer the questions correctly before you're able to move forward. Don't forget to review the rationales for your decisions with each question.

Let the games begin!

Donning PPE

During this interactive video, you will be asked questions about the proper procedure and techniques regarding how to don all PPE.

Please note: there is no sound in this video.

The original video can be found on YouTube.

Text Description

This interactive video teaches learners how to put on, or don, personal protective equipment (PPE) safely. The video pauses at several points for multiple-choice, fill-in-the-blank, and drag-and-drop questions. Learners must answer the questions correctly before continuing.

Part 1: Preparing to put on PPE

The learner is asked:

What is required prior to donning PPE? Select all that apply.

The answer choices are:

- Nails should be short.
- Only clear nail polish is permitted.
- Perform hand hygiene using an alcohol-based hand rub.
- Hair should be pushed behind the shoulders.

Correct responses:

- Nails should be short.
- Perform hand hygiene using an alcohol-based hand rub.

Short nails reduce the risk of puncturing gloves. Nail polish and artificial nails should not be worn because they can harbour microorganisms. Long hair should be securely tied up and kept off the shoulders rather than simply pushed back.

The activity explains that alcohol-based hand rub removes transient microorganisms and decontaminates the hands before PPE is put on. The solution should cover all surfaces of the hands and wrists and be allowed to dry completely.

Part 2: When alcohol-based hand rub should not be used

The learner is asked:

When is an alcohol-based hand rub contraindicated?

The answer choices are:

- When caring for an immunosuppressed client
- After removing sterile gloves
- When the hands and wrists are not visibly soiled
- When the client has been exposed to *Clostridioides difficile* (C. difficile)

Correct response: When the client has been exposed to C. difficile.

Soap and water should be used when a client is known or suspected to have C. difficile because alcohol-based hand rub is not as effective against its spores. Soap and water should also be used whenever the hands are visibly soiled.

Part 3: Putting on the gown

The learner completes the following statement:

The _____ is the first PPE item you don.

The options are protective eyewear, a mask, a gown, and gloves.

Correct response: Gown.

The gown should be securely tied around the neck and waist so that it provides appropriate coverage.

Part 4: Putting on the mask and protective eyewear

The learner drags the correct terms into the following sentence:

The second PPE item you will don is _____, and then you will don _____.

Correct sequence:

1. Mask
2. Protective eyewear

The mask should cover the nose and extend underneath the chin. The metal band at the top of the mask should be pinched and moulded around the bridge of the nose to reduce gaps.

Protective eyewear is put on after the mask.

Part 5: Putting on gloves

The learner is asked:

How do you correctly put on the gloves when donning PPE?

The answer choices are:

- Gloves fit over the cuffs of the gown.
- Gloves fit under the cuffs of the gown.

Correct response: Gloves fit over the cuffs of the gown.

The gloves should cover the gown cuffs and fit properly. Gloves that are too tight or too loose may increase the risk of tearing or contamination.

Correct order for donning PPE

1. Perform hand hygiene.
2. Put on the gown.
3. Put on the mask.
4. Put on protective eyewear.
5. Put on gloves over the gown cuffs.

The activity ends by confirming that the learner has successfully donned the PPE and can enter the client's room safely.

Removing PPE

This interactive video continues from the donning video, after you have completed care on the client, and are expected to remove all PPE in the proper sequence.

Please note: there is no sound in this video.

The original video can be found on YouTube.

Text Description

This interactive video teaches learners how to safely remove, or doff, personal protective equipment (PPE) after completing client care. The video pauses at several points for multiple-choice and drag-and-drop questions about the correct removal sequence and the prevention of contamination.

Part 1: Removing the first item

The learner is asked:

Which PPE item should you remove first?

The answer choices are:

- Gloves
- Gown
- Protective eyewear
- Mask

Correct response: Gloves.

Gloves are removed first because they are likely to be highly contaminated. To remove the first glove, pinch the outside of the glove below the wrist and slowly peel it away, turning it inside out. Use the ungloved hand to reach underneath the remaining glove and peel it away without touching its contaminated outer surface. Discard both gloves safely.

Part 2: Removing the gown

The learner is asked:

What is the next step after you remove your gloves?

The answer choices are:

- Remove your gown
- Apply alcohol-based waterless antiseptic
- Remove your mask
- Remove your protective eyewear

Correct response: Remove your gown.

The gown should be removed carefully without allowing its contaminated outer surface to touch the hands or uniform. It should be rolled inward and away from the body to contain the contaminated surface before being discarded.

The activity notes that hand hygiene should be performed immediately after glove removal when the hands have become contaminated or are visibly soiled.

Part 3: Completing the removal sequence

The learner completes the following sentence by dragging the correct phrases into place:

After you have discarded your gown, you would then _____, then _____, and then _____.

Correct sequence:

1. Perform hand hygiene.
2. Remove protective eyewear.
3. Remove the mask.

When applying alcohol-based hand rub, all surfaces of the hands and wrists must be covered. Protective eyewear should be handled only by the arms or straps because the front may be contaminated. The mask should be removed using its ties or ear loops without touching the front.

Part 4: Final hand hygiene

The learner is asked:

Why is it important to perform hand hygiene before leaving an isolated area? Select all that apply.

The answer choices are:

- To reduce the risk of contaminating yourself
- To reduce the risk of contaminating fellow health-care professionals
- To reduce the risk of contaminating visitors and other clients
- To reduce the risk of contaminating the surrounding environment

Correct responses: All four options.

Final hand hygiene helps prevent microorganisms from being transferred to the health-care provider, other people, equipment, or the surrounding environment.

Correct order for removing PPE

1. Remove gloves.
2. Remove the gown.

3. Perform hand hygiene.
4. Remove protective eyewear.
5. Remove the mask.
6. Perform hand hygiene again.

The activity ends by confirming that the learner has successfully removed the PPE without contaminating themselves and has reduced the risk of spreading contamination to others.

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7.6 Infection Prevention and Control Practices

Infection prevention and control (IPAC) practices are evidence-based procedures and practices that can prevent and reduce disease transmission, and eliminate sources of potential infections (PIDAC, 2012). When used consistently, IPAC practices will prevent the transfer of *healthcare-associated infections (HAIs)* in all health care settings. HAIs, also known as *nosocomial infections*, are infections that occur in any health care setting as a result of contact with a pathogen that was not present at the time the person infected was admitted (World Health Organization [WHO], 2009a).

Two types of techniques are used to prevent infection in the hospital setting. The first, *medical asepsis*, or *clean technique*, has been used in the past to describe measures for reducing and preventing the spread of organisms (Perry, Potter & Ostendorf, 2014). The second, *sterile technique*, also known as *sterile asepsis*, is a strict technique to eliminate all microorganisms from an area (Perry et al., 2014). When a patient is suspected of having or is confirmed to have certain pathogens or clinical presentations, *additional precautions* are implemented by the health care worker, in addition to routine practices (PIDAC, 2012). These additional precautions are based on how an infection is transmitted, such as by contact, droplet, or air. Additional precautions include the use of personal protective equipment (PPE), such as gowns, eyewear, face shields, and masks, along with environmental controls to prevent transmission of infection.

To reduce and prevent the spread of HAIs, routine practices, a system of recommended IPAC practices, are to be used consistently with all patients at all times in all health care settings (Public Health Agency of Canada [PHAC], 2012b). The principles of routine practices are based on the premise that all patients are potentially infectious, even when asymptomatic, and IPAC routine practices should be used to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, or soiled items (PIDAC, 2012).

To learn the steps for routine practices, see Table 7.6.

Table 7.6: Routine Practices

Disclaimer: Always review and follow your hospital policy regarding this specific skill.	
Safety considerations: • Routine practices must be used by all health care professionals, at all times, with all patients/residents/clients in all health care settings. Routine practices will prevent transmission of microorganisms from patient to patient, patient to staff, staff to patient, and staff to staff. • The presence of a pathogen does not predict the onset of an infection. The <i>chain of infection</i> must be present. If the chain of infection is broken, an infection will not occur. Routine practices are used to break or minimize the chain of infection. • Be aware of factors that increase a patient's risk of becoming colonized or infected in the hospital. Increased acuity, advanced age, use of invasive procedures, immunocompromised state of the patient, greater exposure to microorganisms, and an increased use of antimicrobial agents and complex treatments are common risk factors. • Reduce patient susceptibility to infection by encouraging immunizations, providing adequate rest and nutrition, and protecting the body's defences from infection (cover open wounds, keep drainage systems closed and intact, maintain skin integrity). • HAIs can cause symptoms ranging from asymptomatic colonization to septic shock and death, resulting in increased suffering for patients and increased health care costs for Canadians. Ensure that additional precaution guidelines are followed for all suspected and confirmed cases of infections and communicable diseases. • The most common sites for HAIs are the urinary and respiratory systems, and central line-associated bloodstream infections. Consider practices that will reduce infections related to these systems. • The most common types of HAIs in Canada are methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), vancomycin-resistant <i>Enterococci</i> (VRE), and <i>Clostridium difficile</i> (CDI). Ensure all health care providers and visitors follow the additional precautions policies.	
Steps	Additional Information
1. Complete a risk assessment to determine your need for PPE (gown, clean gloves, mask, face shield, or eyewear).	Consider: Will your face, hands, skin, mucous membranes, or clothing be exposed to blood, excretions, or secretions, either by spray, coughing, or sneezing? Will you have contact with the patient's environment/surfaces? Is an infection or communicable disease suspected or confirmed?
2. (Hand washing) following hospital policy.	Hand hygiene is considered the most important and effective measure to prevent HAIs. HAIs are most commonly spread by the hands of health care workers, patients, and visitors. Health care workers, patients, and visitors account for about 80% of all HAIs. Always after using the washroom, coughing, or sneezing, and before and after eating. Using an alcohol-based hand rub (ABHR) is the recommended method for hand hygiene if hands are not visibly soiled.

3. Follow proper cleaning or disinfecting procedures of patients and the environment (room etiquette). These environmental controls will control the site or source of microorganism growth.	Dispose of soiled linens and dressings in the appropriate receptacle bin. Avoid contact of the soiled item with the uniform. Clean contaminated objects and sterilize or disinfect equipment and patient rooms according to agency policy. Discard any item that touches the floor. Control sources of wound drainage and body fluids; change soiled dressings. Avoid shaking bed linen or clothes; dust with a damp cloth as required. Microorganisms can be expelled through the air and inhaled by patients and health care workers. Provide all persons with their own linen and personal items. Place syringes in designated puncture-proof containers. Keep table surfaces dry and clean. Empty and dispose of drainage containers as per agency policy.
4. Follow respiratory etiquette.	Wear a mask if coughing or sneezing. Wear a mask if suffering from a respiratory condition, and consider staying home. Avoid talking, sneezing, or coughing over open wounds and sterile dressings. Practise coughing or sneezing into your upper arm, not your hands. Follow hospital policies related to creating healthy workplaces. Do not come to work ill or with symptoms of a communicable disease (flu or cold) that puts co-workers or patients at risk.
5. Wear clean gloves for appropriate activities based on a risk assessment. Use clean gloves when handling all blood and body fluids.	Follow recommendations for assessing each situation and the need for clean gloves. Improper glove use has been linked to the transmission of microorganisms. Do not wear gloves for activities that do not pose a risk, such as feeding or taking blood pressure. Clean gloves are task-specific and for single use only. Handle all blood, body fluids, and laboratory specimens as if infectious. Always take off clean gloves to reduce the potential of contamination from pathogens on gloves.
6. Use additional precautions guidelines for suspected or known infections or communicable diseases. Use PPEs based on mode of infection transmission (contact, droplet, or airborne).	Follow agency guidelines essential to prevent and reduce transmission of infections. Single rooms, <i>cohorting</i> (placing patients with the same infections in the same room if a private room is not available), restricting visitors, and implementing additional environmental controls may be required. Provide instruction/signage for the appropriate use and disposal of PPE for visitors, patients, and all health care workers. Remove PPE immediately after single use.
7. Do not eat or drink in the patient/client or resident areas.	Eating and drinking increase the risk of transmission of infection between health care providers and patients.

8. Use avoidance procedures/actions to minimize the risk of infection transmission.	If a patient has uncontrolled diarrhea, wear a gown when changing linen to prevent contamination of clothing and hands. If a patient is coughing, sit next to, rather than in front of, the patient when talking to that patient.
Data source: CDC, 2007, 2014; Perry et al., 2014; PIDAC, 2012; PHAC, 2012b, 2013	



Activity: Critical Thinking Exercises

1. Name four environmental procedures that can break the chain of infection.
2. What types of patients are at an increased risk of an HAI?
3. How can health care providers reduce patient susceptibility to infection?

From Theory to Practice

Check your knowledge with this learning activity.

Text Description

1. In most cases, using hand sanitizer is as effective as washing with soap and water. (True/False)
2. If your hands are visibly soiled, it is important to use hand sanitizer for 30 seconds, dry your hands, and re-sanitize for an additional 30 seconds. (True/False)
3. It is appropriate to utilize gloves without hand sanitizing. (True/False)
4. When an individual has Clostridium Difficile (C. Diff.), hand hygiene should be performed using hand sanitizer. (True/False)
5. The process of hand washing with soap and water should take between 10 and 20 seconds. (True/False)

Solutions:

1. True
2. False
3. False
4. False
5. False

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7.7 Other Hygienic Client Care Interventions

Other Hygienic Client Care Interventions

In addition to implementing standard and transmission-based precautions and utilizing aseptic and sterile technique when performing procedures, nurses implement many interventions to place a client in the best health possible to prevent an infection or treat an infection. These interventions include actions like encouraging rest and good nutrition, teaching stress management, providing good oral care, encouraging daily bathing, and changing linens. It is also important to consider how gripper socks, mobile devices, and improper glove usage can contribute to the transmission of pathogens.

Oral Care

Client hygiene is important in the prevention and spread of infection. Although oral care may be given a low priority, research has found that poor oral care is associated with the spread of infection, poor health outcomes, and poor nutrition. Oral care should be performed in the morning, after meals, and before bed.

Daily Bathing

Daily bathing is another intervention that may be viewed as time-consuming and receive low priority, but it can have a powerful impact on decreasing the spread of infection. Studies have shown a significant decrease in healthcare-associated infections with daily bathing using chlorhexidine gluconate (CHG) wipes or solution. The use of traditional soap and water baths does not reduce infection rates as significantly as CHG products, and wash basins have also been shown to be a reservoir for pathogens.

Linens

Changing bed linens, towels, and a gown regularly eliminates potential reservoirs of bacteria. Fresh linens also promote client comfort.

Gripper Socks

Have you ever thought about what happens to the bed linens when a client returns from a walk in the hallway with gripper socks and gets back into bed with these socks? Research demonstrates that pathogens from the floor are transferred to the client's bed linens from the gripper socks. Nurses should remove gripper socks that were used for walking before clients climb into bed. They should also throw the socks away when the client is discharged instead of sending them home.

Cellular Phones and Mobile Devices

Research has shown that cell phones and mobile devices carry many pathogens and are dirtier than a toilet seat or the bottom of a shoe. Clients, staff, and visitors routinely bring these mobile devices into health care facilities, which can cause the spread of disease. Nurses should frequently wipe mobile devices with disinfectant. They should encourage clients and visitors to disinfect phones frequently and avoid touching the face after having touched a mobile device.

Gloves

Although gloves are used to prevent the spread of infection, they can also contribute to the spread of infection if used improperly. For example, research has shown that hand hygiene opportunities are being missed because of the overuse of gloves. For example, a nurse may don gloves to suction a client but neglect to remove them and perform hand hygiene before performing the next procedure on the same client. This can potentially cause the spread of secondary infection. The World Health Organization (WHO) states that gloves should be worn when there is an expected risk of exposure to blood or body fluids or to protect the hands from chemicals and hazardous drugs, but hand hygiene is the best method of disease prevention and is preferred over wearing gloves when the exposure risk is minimal.

Nurses have the perception that wearing gloves provides extra protection and cleanliness. However, the opposite is true. Nonsterile gloves have a high incidence of contamination with a range of bacteria, which means that a gloved hand is dirtier than a washed hand. Research has shown that nearly 40% of the time that gloves are used in client care, there is cross-contamination. The most striking example of cross-contamination includes situations when gloves are used for toileting a client and are not removed before touching other surfaces or the client.¹

Glove-related contact dermatitis has also become an important issue in recent years as more and more nurses are experiencing damage to their hands. Contact dermatitis can develop from repeated use of gloves and develops as dry, itchy, irritated areas on the skin of the hands. See *Figure 7.7* for an image of contact dermatitis from gloves. Because the skin is the first line of defence in preventing pathogens from entering the body, maintaining intact skin is very important to prevent nurses from exposure to pathogens.

1.



Figure 7.7: *Contact Dermatitis*

From Theory to Practice

Removing Gloves Interactive Video

During this interactive video, you will be tested on your knowledge of how to properly remove non-sterile gloves. As you watch the interactive video, you will be asked questions throughout the performance of the skill. You must answer the questions correctly before you're able to move forward. Don't forget to review the rationales for your decisions with each question.

Begin to remove your gloves!

Video: "Removing Non-Sterile Gloves." by Michelle H [0:50] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Text Description

This interactive video demonstrates how to remove non-sterile gloves safely. The video pauses for questions that learners must answer correctly before continuing.

Part 1: Understanding the protection provided by gloves

The learner responds to the following true-or-false statement:

Gloves can provide complete protection from microorganisms.

Correct response: False.

Gloves can reduce the transmission of microorganisms and decrease contamination of the hands, but they do not provide complete protection. Hand hygiene is still required before putting on gloves and after removing them.

Part 2: Identifying the benefit of wearing gloves

The learner is asked:

What are the benefits of wearing gloves?

The answer choices are:

- Replaces the need for hand hygiene
- Reduces transmission of pathogens
- Can be reused for the same client
- Can be worn for long durations during care

Correct response: Reduces transmission of pathogens.

Gloves help reduce the transfer of pathogens between the health-care provider, the client, and the environment. Gloves do not replace hand hygiene and must never be washed, reused, or worn again. They should be worn only for the task for which they are required and removed as soon as that task is complete.

Part 3: Removing the gloves

The video demonstrates the safe removal of non-sterile gloves:

1. Grasp the outside of one glove near the wrist without touching the skin.
2. Peel the glove away from the hand, turning it inside out.
3. Hold the removed glove in the still-gloved hand.
4. Slide the fingers of the ungloved hand underneath the remaining glove at the wrist.
5. Peel the second glove away from the hand and over the first glove, containing both gloves together.
6. Discard the gloves in the appropriate waste receptacle.
7. Perform hand hygiene.

An on-screen message reminds the learner:

It is important not to touch the outside of the gloves with your ungloved hand to avoid contamination.

The activity ends after the learner reviews the complete glove-removal technique.

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7.8 Surgical Asepsis and the Principles of Sterile Technique

Surgical Asepsis

Asepsis refers to the absence of infectious material or infection. *Surgical asepsis* is the absence of all microorganisms within any type of invasive procedure. *Sterile technique* is a set of specific practices and procedures performed to make equipment and areas free from all microorganisms and to maintain that sterility. In the literature, surgical asepsis and sterile technique are commonly used interchangeably, but they mean different things (Kennedy, 2013). Principles of sterile technique help control and prevent infection, prevent the transmission of all microorganisms in a given area, and include all techniques that are practised to maintain sterility.

Sterile technique is most commonly practised in operating rooms, labour and delivery rooms, and special procedures or diagnostic areas. It is also used when performing a sterile procedure at the bedside, such as inserting devices into sterile areas of the body or cavities (e.g., insertion of a chest tube, central venous line, or indwelling urinary catheter). In health care, sterile technique is always used when the integrity of the skin is assessed, impaired, or broken (e.g., burns or surgical incisions). Sterile technique may include the use of sterile equipment, sterile gowns, and gloves (Perry et al., 2014).

Sterile technique is essential to help prevent *surgical site infections (SSI)*, an unintended and oftentimes preventable complication arising from surgery. SSI is defined as an “infection that occurs after surgery in the area of surgery” (CDC, 2012). Preventing and reducing SSI are the most important reasons for using sterile technique during invasive procedures and surgeries.

Principles of Surgical Asepsis

All personnel involved in an aseptic procedure are required to follow the principles and practices set forth by the Association of Perioperative Registered Nurses (AORN). These principles must be strictly applied when performing any aseptic procedures, when assisting with aseptic procedures, and when intervening when the principles of surgical asepsis are breached. It is the responsibility of all healthcare workers to speak up and protect all patients from infection. See *Table 7.8* for the principles of sterile technique.

Table 7.8: Principles of Sterile Technique

Disclaimer: Always review and follow your hospital policy regarding this specific skill.	
Safety considerations: • Hand hygiene is a priority before any aseptic procedure. • When performing a procedure, ensure the patient understands how to prevent contamination of equipment and knows to refrain from sudden movements or touching, laughing, sneezing, or talking over the sterile field. • Choose appropriate PPE to decrease the transmission of microorganisms from patients to health care worker. • Review hospital procedures and requirements for sterile technique prior to initiating any invasive procedure. • Health care providers who are ill should avoid invasive procedures or, if they can't avoid them, should double mask.	
Steps	Additional Information
1. All objects used in a sterile field must be sterile.	Commercially packaged sterile supplies are marked as sterile; other packaging will be identified as sterile according to agency policy. Check packages for sterility by assessing intactness, dryness, and expiry date prior to use. Any torn, previously opened, or wet packaging, or packaging that has been dropped on the floor, is considered non-sterile and may not be used in the sterile field.
2. A sterile object becomes non-sterile when touched by a non-sterile object.	Sterile objects must only be touched by sterile equipment or sterile gloves. Whenever the sterility of an object is questionable, consider it non-sterile. Fluid flows in the direction of gravity. Keep the tips of forceps down during a sterile procedure to prevent fluid travelling over entire forceps and potentially contaminating the sterile field.
3. Sterile items that are below the waist level, or items held below waist level, are considered to be non-sterile.	Keep all sterile equipment and sterile gloves above waist level. Table drapes are only sterile at waist level.
4. Sterile fields must always be kept in sight to be considered sterile.	Sterile fields must always be kept in sight throughout entire sterile procedure. Never turn your back on the sterile field as sterility cannot be guaranteed.
5. When opening sterile equipment and adding supplies to a sterile field, take care to avoid contamination.	Set up sterile trays as close to the time of use as possible. Stay organized and complete procedures as soon as possible. Place large items on the sterile field using sterile gloves or sterile transfer forceps. Sterile objects can become non-sterile by prolonged exposure to airborne microorganisms.
6. Any puncture, moisture, or tear that passes through a sterile barrier must be considered contaminated.	Keep sterile surface dry and replace if wet or torn.
7. Once a sterile field is set up, the border of one inch at the edge of the sterile drape is considered non-sterile.	Place all objects inside the sterile field and away from the one-inch border.
8. If there is any doubt about the sterility of an object, it is considered non-sterile.	Known sterility must be maintained throughout any procedure.

9. Sterile persons or sterile objects may only contact sterile areas; non-sterile persons or items contact only non-sterile areas.	The front of the sterile gown is sterile between the shoulders and the waist, and from the sleeves to two inches below the elbow. Non-sterile items should not cross over the sterile field. For example, a non-sterile person should not reach over a sterile field. When opening sterile equipment, follow best practice for adding supplies to a sterile field to avoid contamination. Do not place non-sterile items in the sterile field.
10. Movement around and in the sterile field must not compromise or contaminate the sterile field.	Do not sneeze, cough, laugh, or talk over the sterile field. Maintain a safe space or margin of safety between sterile and non-sterile objects and areas. Refrain from reaching over the sterile field. Keep operating room (OR) traffic to a minimum, and keep doors closed. Keep hair tied back. When pouring sterile solutions, only the lip and inner cap of the pouring container is considered sterile. The pouring container must not touch any part of the sterile field. Avoid splashes.
Data source: Kennedy, 2013; Infection Control Today, 2000; ORNAC, 2011; Perry et al., 2014; Rothrock, 2014	



Video: Principles of Asepsis

Video: “Principles of Asepsis” by Renée Anderson & Wendy McKenzie [6:39] is licensed under a Creative Commons 4.0 International License. *Transcript available [PDF].*



Activity: Critical Thinking Exercises

1. When should a sterile field be opened (under normal circumstances)?
2. What part of the sterile field is considered non-sterile?

Clinical Techniques to Reduce the Transmission of Healthcare-Associated Infections (HAIs)

Two types of techniques are used to prevent infection in the hospital setting. The first, *medical asepsis* or *clean technique*, has been used historically to describe measures for reducing and preventing the spread of

organisms. The second, *sterile technique*, also known as *sterile asepsis*, is a strict technique to eliminate all microorganisms from an area (Potter et al., 2019).

When a client is suspected of having or is confirmed to have certain pathogens or clinical presentations, *additional precautions* are implemented by the healthcare worker in addition to routine practices (PIDAC, 2012). These additional precautions are based on how an infection is transmitted, such as by contact, droplet, or airborne. Additional precautions include the use of personal protective equipment (PPE), such as gowns, eyewear, face shields, and masks, along with environmental controls to prevent transmission of infection.

To reduce and prevent the spread of HAIs, a system of recommended IPAC *routine practices* is to be used consistently with all clients at all times in all healthcare settings. The principles of routine practices are based on the premise that all clients are potentially infectious, even when asymptomatic, and IPAC routine practices should be used to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, or soiled items (PIDAC, 2012).



Image: "Additional Precautions" by Hughes et al., CC BY-NC 4.0.



Activity: Test Your Understanding

Text Description

This four-part case-based activity asks learners to identify a possible health care-associated infection and select appropriate infection prevention and control practices.

An accompanying photograph shows a smiling older adult with short grey hair and a white beard, wearing a light-grey buttoned shirt against a grey background.

Part 1: Client information

The activity presents the following case:

Biographical data: A 78-year-old client.

Reason for seeking care: Diarrhea and abdominal pain without a fever.

History of presenting illness: The client was recently admitted to hospital for a total hip replacement. They received prophylactic antibiotics before surgery to reduce the risk of postoperative infection, but received no additional antibiotics during the admission. The client was discharged after three days. Approximately three weeks later, they developed diarrhea and abdominal pain. Laboratory testing revealed an elevated white blood cell count.

Medical history: Arthritis, hypertension, and pre-diabetes.

Part 2: Identifying the possible infection

The learner is asked:

Given the client's presentation, what health care-associated infection should the health-care provider consider?

The answer choices are:

- C. difficile
- MRSA
- VRE
- MDR-TB

Correct response: C. difficile.

The client's diarrhea, abdominal pain, elevated white blood cell count, recent hospitalization, and exposure to antibiotics could indicate a C. difficile infection.

Part 3: Selecting infection prevention and control practices

The learner is asked:

What infection prevention and control practice should the health-care provider implement? Select all that apply.

The answer choices are:

- Gloves

- Gown
- Mask
- N95 respirator
- Hair net

Correct responses:

- Gloves
- Gown

Gloves and a gown are required because *C. difficile* is managed using contact precautions. A mask, N95 respirator, and hair net are not routinely required for contact precautions.

Part 4: Responding to a food-sharing situation

The client's family brings a large box of Timbits to share with hospital staff as an expression of appreciation. The learner is asked to identify the health-care provider's best response.

The answer choices are:

- Respectfully decline because sharing food may contribute to the transmission of *C. difficile*.
- Perform hand hygiene in front of the family and eat a Timbit.
- Accept a Timbit and save it for later in the lunchroom.
- Accept a Timbit so the family does not view declining it as disrespectful.

Correct response: Respectfully decline because sharing food may contribute to the transmission of *C. difficile*.

The activity explains that *C. difficile* can be transmitted through direct and indirect contact.

Text Description

This two-part case-based activity presents a healthcare provider who seeks emergency care after experiencing a needlestick injury. Learners review the client information and reflect on the appropriate post-exposure response.

An accompanying photograph shows a smiling adult wearing a purple top and a patterned scarf while holding a blue folder.

Part 1: Client information

The activity presents the following case:

Biographical data: A 52-year-old healthcare provider.

Reason for seeking care: The client presents to the emergency department after a needlestick injury. The client washed and irrigated the affected area with soap and water but is concerned because the needle had been used with a person who has a confirmed hepatitis B infection.

History of presenting illness: The client completed the three-dose hepatitis B vaccination series, but their anti-HB status is unknown. Bloodwork is collected to determine HBsAg, anti-HBc, and total anti-HB levels.

Medical history: The client takes a low-dose selective serotonin reuptake inhibitor, or SSRI.

Part 2: Reflective questions

After reviewing the case, the learner considers the following questions:

- What guidelines should be followed when caring for the client?
- What should the healthcare provider consider next when planning the client's care?

The activity encourages learners to consider institutional needlestick and occupational-exposure protocols, hepatitis B immunity and testing results, documentation and reporting requirements, and the need for follow-up care.

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7.9 Chapter Summary



Key Takeaways

Infection prevention and control are critical factors that all health care professionals, including nurses, must keep in mind when providing care to patients. Health care-associated infections must be prevented because they lead to complications in patient recovery and longer hospital stays. They can range from mild irritations to life-threatening conditions like sepsis, and are frequently caused by antibiotic-resistant bacteria (NHI, 2025). Therefore, following professional, ethical, legal, and organizational responsibilities, nurses are expected to know and apply fundamental infection prevention and control guidelines that ensure patient and staff health and well-being.



Knowledge Check

Text Description

This multiple-choice activity asks learners to identify what is required before performing hand hygiene. Learners select all applicable answers and then choose Check to submit their response. The answer choices are displayed in a random order, and learners may retry the activity.

The question is:

What is required before you perform hand hygiene? Select all that apply.

The answer choices are:

- Remove bracelets.
- Fingernails should be short.
- Assess hands for visible soil.
- Rings should not have jewels or stones.

Solution

The correct responses are:

- Remove bracelets.
- Fingernails should be short.
- Assess hands for visible soil.

The statement “Rings should not have jewels or stones” is not selected. Jewellery should be removed when it interferes with effective hand hygiene or according to organizational policy.

Text Description

This drag-and-drop activity asks learners to place five hand hygiene techniques in the correct order. Learners drag each technique into the appropriate numbered step and select Check to submit their response. Incorrect responses can be retried.

The techniques are:

- Apply soap
- Check for visible soil on the hands
- Dry the hands
- Scrub the hands
- Wet the hands

Solution

The correct order is:

1. Check for visible soil on the hands.

2. Wet the hands.
 3. Apply soap.
 4. Scrub the hands.
 5. Dry the hands.
-

Text Description

This multiple-choice activity asks learners to identify the appropriate water flow and temperature for handwashing. Learners select one answer and then choose Check to submit their response. The answer choices appear in a random order, and learners may retry the activity.

The question is:

What is the appropriate flow and water temperature when washing your hands?

The answer choices are:

- A medium flow and warm water
- A fast flow and cool water
- A slow flow and warm water
- A medium flow and hot water

Solution

The correct response is:

A medium flow and warm water

A moderate water flow helps reduce splashing, while warm water supports comfortable and effective handwashing without irritating the skin.

Text Description

This true-or-false activity asks learners to identify the correct positioning of the hands and forearms during handwashing. Learners select an answer and choose Check to submit their response. Incorrect answers may be retried.

The statement is:

Your hands and forearms should be lower than your elbows when performing a hand hygiene routine.

Solution

Correct response: True.

Keeping the hands and forearms below the elbows allows water to flow toward the fingertips and into the sink rather than back toward the cleaner areas of the arms.

Text Description

This multiple-choice activity asks learners what action to take if their hands touch the sink while

washing their hands. Learners select one response and choose Check to submit their answer. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

What should you do if your hands touch the sink while you are washing your hands?

The answer choices are:

- Repeat the procedure.
- Continue to wash your hands.
- Add more soap to your hands.
- Apply more friction during the procedure.

Solution

Correct response: Repeat the procedure.

The sink is considered contaminated. If the hands touch it during handwashing, the hand hygiene procedure must be restarted to avoid transferring microorganisms back onto the hands.

Text Description

This true-or-false activity asks learners to identify the correct positioning of the hands and elbows while rinsing away soap during handwashing. Learners select an answer and choose Check to submit their response. Incorrect answers may be retried.

The statement is:

It is important to remove all the soap from your wrists and hands, keeping your hands up and your elbows down to rinse away the microorganisms.

Solution

Correct response: False.

The hands should be kept lower than the elbows while rinsing. This allows water and microorganisms to flow downward toward the fingertips and into the sink rather than back toward the wrists and forearms.

Text Description

This multiple-choice activity asks learners to identify the correct way to dry their hands after handwashing. Learners select one answer and choose Check to submit their response. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

How should you dry your hands?

The answer choices are:

- Dry your hands thoroughly.
- Dry from the wrists to the fingertips in one direction.
- Lightly pat your hands and allow them to air dry.

- Dry in a circular motion, covering all areas of the hands and wrists.

Solution

Correct response: Dry your hands thoroughly.

Hands should be dried completely because moisture can support the transfer of microorganisms and may contribute to skin irritation.

Text Description

This drag-and-drop activity asks learners to complete a sentence about the correct direction for drying the hands after handwashing. Learners drag the appropriate terms into the two blank spaces and select Check to submit their response. Incorrect responses may be retried.

The sentence is:

Dry your hands from _____ to _____.

Solution

The correct completed sentence is:

Dry your hands from fingertips to wrists.

Text Description

This true-or-false activity asks learners how to turn off the faucet after washing and drying their hands. Learners select an answer and choose Check to submit their response. Incorrect answers may be retried.

The statement is:

You should use a dry, clean paper towel when turning off the faucet.

Solution

Correct response: False.

The faucet should be turned off using the paper towel that was used to dry the hands, rather than using a separate clean paper towel. This prevents clean hands from directly touching the potentially contaminated faucet handle.

Text Description

This multiple-choice activity asks learners to identify the correctly sized pair of non-sterile gloves. An image shows three pairs of gloved hands labelled A, B, and C.

Image A: The gloves are too small and fit tightly across the hands and fingers.

Image B: The gloves fit closely and comfortably without excessive tightness or loose material.

Image C: The gloves are too large, with excess material and wrinkling around the fingers and hands.

The question is:

Which glove is the appropriate size?

The answer choices are:

- Small (Image A)
- Medium (Image B)
- Large (Image C)

Solution

Correct response: Medium (Image B).

Properly sized gloves should fit securely without restricting movement or leaving excess material. Gloves that are too small may tear, while gloves that are too large may reduce dexterity and interfere with safe care.

Text Description

This true-or-false activity asks learners to identify whether alcohol-based hand rub is generally the preferred method of hand hygiene. Learners select an answer and choose Check to submit their response. Incorrect answers may be retried.

The statement is:

Alcohol-based hand rub is the preferred method of hand hygiene.

Solution

Correct response: True.

Alcohol-based hand rub is generally preferred for routine hand hygiene when the hands are not visibly soiled. Soap and water should be used when hands are visibly dirty or when caring for a client with an organism such as *Clostridioides difficile*.

Text Description

This multiple-choice activity asks learners to identify an infection that requires handwashing with soap and water. Learners select one answer and choose Check to submit their response. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

For which of the following infections should you use handwashing with soap and water?

The answer choices are:

- *Clostridium difficile*
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Hepatitis A virus
- Pneumonia

Solution

Correct response: *Clostridium difficile*.

Soap and water should be used when caring for a client with *C. difficile* because its spores are not effectively removed by alcohol-based hand rub alone.

Text Description

This multiple-choice activity asks learners to identify the type of client for whom the use of an alcohol-based waterless antiseptic is encouraged. Learners select one answer and choose Check to submit their response. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

Use of alcohol-based waterless antiseptic is encouraged for which types of clients?

The answer choices are:

- Immunosuppressed clients
- Newborn clients
- Clients with lesions
- Clients with dermatitis

Solution

Correct response: Immunosuppressed clients.

Alcohol-based hand rub is encouraged when caring for immunosuppressed clients because effective hand hygiene helps reduce their exposure to harmful microorganisms. It should be used when the hands are not visibly soiled, and no condition requiring soap and water is present.

Text Description

This true-or-false activity asks learners whether their hands should be allowed to dry before gloves are applied. Learners select an answer and choose Check to submit their response. Incorrect answers may be retried.

The statement is:

Allow hands to dry before applying gloves to ensure full antiseptic effect.

Solution

The activity is currently set to: False.

However, this answer setting should be reviewed. Hands should generally be allowed to dry completely after using alcohol-based hand rub before gloves are applied. Applying gloves while the hands are still wet can reduce comfort, irritate the skin, and make the gloves more difficult to put on.

Text Description

This multiple-choice activity asks learners to identify the benefits of using an alcohol-based hand rub when the hands are not visibly soiled. Learners select all applicable answers and choose Check to

submit their response. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

What are the benefits of performing alcohol-based hand rub when hands are not visibly soiled? Select all that apply.

The answer choices are:

- Takes less time
- Causes less drying to the hands
- Is more effective than soap and water when hands are not visibly soiled
- Removes all bacteria and viruses

Solution

The correct responses are:

- Takes less time
- Causes less drying to the hands
- Is more effective than soap and water when hands are not visibly soiled

The statement “Removes all bacteria and viruses” is incorrect. Alcohol-based hand rub reduces many harmful microorganisms but does not eliminate every type of bacterium or virus.

Text Description

This true-or-false activity asks learners whether all areas of the hands and wrists must be covered when applying alcohol-based hand rub. Learners select an answer and choose Check to submit their response. Incorrect answers may be retried.

The statement is:

It is important to cover all areas of your hands, including wrists, when performing an alcohol-based hand rub.

Solution

Correct response: True.

Alcohol-based hand rub should be applied to all surfaces of the hands and wrists, including the palms, backs of the hands, between the fingers, fingertips, thumbs, and around the wrists. The hands should be rubbed together until completely dry.

Text Description

This drag-and-drop activity asks learners to place the steps for donning personal protective equipment (PPE) in the correct order. Learners drag each item into the appropriate numbered step and select Check to submit their response. Incorrect responses may be retried.

The items are:

- Eyewear
- Gloves
- Gown
- Hand hygiene
- Mask

Solution

The correct order is:

- Perform hand hygiene.
 - Put on the gown.
 - Put on the mask.
 - Put on protective eyewear.
 - Put on gloves.
-

Text Description

This drag-and-drop activity asks learners to place the steps for removing personal protective equipment (PPE) in the correct order. Learners drag each item into the appropriate numbered step and select Check to submit their response. Incorrect responses may be retried.

The items are:

- Gloves
- Gown
- Hand hygiene
- Protective eyewear
- Mask
- Hand hygiene

Solution

The correct order is:

1. Remove gloves.
 2. Remove the gown.
 3. Perform hand hygiene.
 4. Remove protective eyewear.
 5. Remove the mask.
 6. Perform hand hygiene again.
-

Text Description

This multiple-choice activity asks learners to identify how gloves should be positioned when donning personal protective equipment (PPE). Learners select one answer and choose Check to submit their response. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

How do you correctly put on the gloves when donning PPE?

The answer choices are:

- Gloves fit over the cuff of the gown.
- Gloves fit under the cuff of the gown.

Solution

Correct response: Gloves fit over the cuff of the gown.

The gloves should extend over the gown cuffs to cover the wrists and reduce the risk of exposing skin or clothing during client care.

Text Description

This multiple-choice activity asks learners why hand hygiene must be performed before leaving an isolation area. Learners select all applicable answers and choose Check to submit their response. The answer choices appear in a random order, and learners may retry an incorrect response.

The question is:

Why is it important to perform hand hygiene before leaving an isolation area? Select all that apply.

The answer choices are:

- To reduce the risk of contaminating yourself.
- To reduce the risk of contaminating fellow health-care professionals.
- To reduce the risk of contaminating visitors and other clients.
- To reduce the risk of contaminating the surrounding environment.

Solution

All four responses are correct.

Performing hand hygiene before leaving an isolation area helps prevent microorganisms from spreading to the health-care provider, other people, equipment, and the surrounding environment.



For Further Reflection

- What will you do to ensure and promote infection prevention and control in your nursing practice as a student nurse and as a registered nurse?
- What barriers to ensuring infection prevention and control in your nursing practice might you encounter?

What would you do and say as the nurse?



Patient with Abdominal Drain Wound: Case Study Analysis

Review the scenario

Key Points

According to the CNO's Professional Boundaries and Nurse-Client Relationships practice standard, nurses are accountable to protect patients from harm. This applies to protecting them from infection risks. Nurses have a commitment to quality practice settings, as highlighted in the Code of Conduct. All nurses, regardless of their position, need to advocate for quality practices, which may include professional development systems, organizational support, equipment and care delivery processes. They demonstrate maintaining commitments to quality practice settings by:

- continually evaluating the workplace (including community settings such as patients' homes) and environment to identify opportunities for improving the quality of care
- respecting organizational policies
- making those in authority aware of concerns within the setting
- exploring solutions within the setting to meet the patient's and the setting's needs
- advocating for nursing input on patient care policies

The home health nurse can reduce the patient's risk of infection by:

- reviewing relevant organizational policies on infection prevention and control
- identifying patient and nurse risks by:
 - identifying hazards and injury potential
 - intervening and providing appropriate care to her patient, herself or another health care provider after exposure
 - reporting an infection control technique breach and taking action to limit further harm and to prevent risks
 - applying and advocating for evidence-based practice such as
 - applying hand hygiene principles
 - choosing appropriate measures to prevent and control infection transmission, such as donning appropriate protective equipment
 - applying principles for safely handling, cleaning and disposing of materials and equipment

- communicating with and educating the patient (for example, setting expectations and providing rationale)
- collaborating with the patient and health care team on a plan of care that meets the patient's needs and promotes safety

CHAPTER 8: FROM THEORY TO PRACTICE – SIMULATION BASED LEARNING

Chapter 8 Overview



- 8.0 Learning Objectives
- 8.1 Chapter Introduction
- 8.2 Simulation 1
- 8.3 Simulation 2
- 8.4 Simulation 3
- 8.5 Simulation 4
- 8.6 Simulation 5
- 8.7 Simulation 6
- 8.8 Simulation 7
- 8.9 Chapter Summary

8.0 Learning Objectives



Learning Objectives

By the end of this chapter, you will be able to:

1. Explain the importance of establishing therapeutic nurse-client relationships as the foundation for providing nursing care.
2. Apply gained knowledge and skills for establishing therapeutic nurse-client relationships while integrating cultural humility, trauma-informed care, and strength-based nursing approaches to care.
3. Reflect on gained knowledge as well as the practice and skills needed to improve establishing effective therapeutic nurse-client relationships in any context of care.
4. Demonstrate critical thinking and clinical judgement when practicing how to do a holistic health interview while collecting data and planning appropriate nursing interventions following professional, ethical, and legal responsibilities of nursing practice.
5. Examine ways to practice and promote the safety of the patients, nurse, health care team, and everyone involved with the patient as they learn to practice in a competent, ethical, caring, and compassionate manner.
6. Analyze potential causes of conflict with patients, family members, and colleagues to identify ways to manage and use it as an opportunity for personal and professional growth for everyone involved.
7. Identify and review normal/expected vital sign ranges for diverse patient populations and explain how external factors like age, pain, stress, and medications affect baseline readings.
8. Examine and review the importance of general nursing interventions to prevent and control infection when providing nursing care.

8.1 Chapter Introduction

The purpose of this chapter is to provide you with various opportunities to review, apply, and critically think about how you might interact with patients in a hospital, clinical, and community environment. In the following chapter sections, you will find seven case scenarios. Each section will provide you with a brief description of a patient situation similar to what you might get during a clinical experience or before a lab-simulation practice. After you read each scenario, review the content covered in this textbook and any other appropriate resources you might need to access, so you can prepare to “assess” and interact with your patient. Write down your findings and any key areas of your interaction-assessment of the client before watching the video provided for you.

For each scenario, a video of a student nurse-client interaction simulation has been posted for you. All the scenarios are lab simulations with simulated patients. There are no real-life patients in any of the seven scenarios. All the student nurses are students from the Western-Fanshawe Collaborative BScN program from year 2 or 3. Many heartfelt thanks and appreciation to all the Fanshawe College faculty and students who participated in this project and made the videos a reality to help students learn and reflect about safe, competent, ethical, caring and compassionate nursing practice.

After reading each case scenario, consider the following general areas below and write down key points of the nursing care you would provide to the client.

Before Watching

For each case, BEFORE watching the video, consider:

- What do you need to know/prepare to provide care to the client?
- How will you establish a TNCR with the client?
- What will you say to the client based on what you have learned about nursing so far? How will you start the interaction?
- What might be part of the client's needs? How might you help the client?
- What data (Subjective & Objective) do you need to collect about the client?

After Watching

For each case, AFTER watching the video, consider:

- How did the student nurse start the interview?
- How did the student nurse establish a TNCR with the client?
- How did the student nurse assess the client's needs?
- What did you notice (verbal and nonverbal communication) about the client and the student nurse?
- What were the client's needs? How did the student nurse attempt to meet the client's needs?
- What are some examples of effective therapeutic communication skills used in the video? What other therapeutic techniques might you use to assess and interact with the client?
- What are some examples that were not effective in communicating with the client? How might you repair/improve the communication you observed with the client?
- How might you improve your interaction with the client?
- What will you communicate (report) to the "team" about the interaction-assessment of the client?
- What will you document (SO[AP]) about the interview?

8.2 Simulation 1

The patient has come to the clinic to get their blood pressure checked. They were recently told they had high blood pressure and need to check it often.

Video: “Holistic Health Assessment: TNCR – Skills” by Fanshawe OER Design Studio [16:52] is licensed under the Standard YouTube License. *Captions Available.*



Nursing Student:
Maya Abdul Hamid



Patient Actor:
Dallas Love



Faculty Direction:
Lorena Bonilla



Production:
Maddy Richard

8.3 Simulation 2

Your patient has come to the clinic complaining of headaches and neck discomfort from working long hours on the computer.

Video: “Holistic Health Assessment: Health Hx Interview & VS” by Fanshawe OER Design Studio [19:29] is licensed under the Standard YouTube License. *Captions Available.*



Nursing Student:

Leah Amaral



Patient Actor:

Koen Liddiard



Faculty Direction:

Lorena Bonilla



Production:

Maddy Richard

8.4 Simulation 3

You are a community health nurse and have been assigned to a new mom and their baby.

Video: “Holistic Health Assessment: New Mom – Depression” by Fanshawe OER Design Studio [11:59] is licensed under the Standard YouTube License. *Captions available.*



Nursing Student:

Kate Sontag



Patient Actor:

Shauna Roch



Faculty Direction:

Lorena Bonilla



Production:

Maddy Richard

8.5 Simulation 4

You must check on a new patient brought to the hospital by a friend. The patient is a minor and was found unconscious after engaging in heavy drinking at a party. The parents-guardians are not aware of the situation. The patient is very afraid and insists they don't want their parents to be notified because "they will kill me and I don't drink".

Video: "Holistic Health Assessment: Alcohol – Minor" by Fanshawe OER Design Studio [10:34] is licensed under the Standard YouTube License. *Captions Available.*



Nursing Student:

Morgan Conlan



Patient Actor:

Negin Zahrooni



Faculty Direction:

Lorena Bonilla



Production:

Maddy Richard

8.6 Simulation 5

Your client is at the clinic to be seen by the oncologist. They were just diagnosed with lung cancer. The nurse preceptor working with you today tells you that the client is not very happy with the staff and health care in general. This is a mean and obnoxious person, so “be careful and remember you don’t have to take crap from people!” This person will be a “good learning experience for you”.

Video: “Holistic Health Assessment: Conflict – Lung Cancer” by Fanshawe OER Design Studio [26:10] is licensed under the Standard YouTube License. *Captions Available.*

**Nursing Student:**

Isaiah Baker

**Patient Actor:**

Anonymous

**Faculty Direction:**

Lorena Bonilla

**Production:**

Maddy Richard

8.7 Simulation 6

You have been assigned a client who is complaining of stomach pain that does not seem to be very serious. This patient has come to the ER several times before complaining of stomach discomfort, so they are considered to be a “frequent flyer”. The wife is always present and won’t leave the patient alone for a second. They just look at everyone “funny” and seem like they don’t want to be in the hospital, but keep coming back frequently. “They always nod and say they will take Pepto-Bismol, Tums, or Mylanta as needed but obviously don’t follow through and just keep coming back for attention!”. They speak Spanish and “get by” with their English.

Video: “Holistic Health Videos: PTSD – Translator” by Fanshawe OER Design Studio [33:11] is licensed under the Standard YouTube License. *Closed captions available.*

Nursing Student:

Katalina Pinzon

Patient Actors:

Matheus Salvalaggio
Carolina Micolini

Faculty Direction:

Lorena Bonilla

Production:

Maddy Richard

8.8 Simulation 7

You are a community palliative care nurse and are checking on one of your clients who requested a visit following their last doctor's check.

Video: "Holistic Health Assessment: TNCR – Death" by Fanshawe OER Design Studio [15:46] is licensed under the Standard YouTube License. *Captions Available.*

Nurse:

Lorena Bonilla

Patient Actor:

Shawn Ryan

Production:

Maddy Richard

8.9 Chapter Summary

According to the International Council of Nurses (van Wicklin, 2026), nursing is a profession centred on enhancing health equity and ensuring access to care through collaborative, culturally safe, and compassionate practices. Nurses integrate scientific knowledge, ethics, and therapeutic relationships to protect health, advocate for patients, and lead within healthcare systems. Therefore, it is important for nurses to practice in a safe, competent, ethical, caring and compassionate manner when providing care to patients. They must be able to practice in a manner that integrates cultural humility, trauma-informed care, and strength-based nursing approaches to care when conducting holistic health assessments to be able to meet patient needs.



For Further Reflection

How will you ensure you continue improving your nursing therapeutic communication and assessment skills? What can you do every week to check the effectiveness of your practice during classes and lab sessions when you are working with course professors, lab instructors, classmates, and standardized patients? How do you feel overall about nursing practice and your ability to be safe, competent, ethical, caring, and compassionate when you practice nursing? What kind of nurse do you hope to become, and how does your goal align with the professional, ethical, and legal responsibilities of nursing practice?

APPENDIX A: SUBJECTIVE HEALTH ASSESSMENT CATEGORIES

Appendix A Overview



- A.1 Introductory Information: Demographic and Biographic Data
- A.2 Main Health Needs/Reasons for Seeking Care
- A.3 Current and Past Health
- A.4 Mental Health and Mental Illnesses
- A.5 Functional Health
- A.6 Preventative Treatments and Examinations
- A.7 Family Health
- A.8 Cultural Health
- A.9 Developmental Considerations

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A.1 Introductory Information: Demographic and Biographic Data

“Introductory information” refers to the *demographic and biographic data* that you collect from the client. This data provides you with basic characteristics about the client, such as their name, contact information, birthdate and age, gender, gender pronouns, allergies, languages spoken and preferred language, relationship status, occupation, and resuscitation status.

Although this data is brief and succinct, the intent of collecting it is not to be reductionist or to label clients. Rather, it is meant as a *brief overview* of the client, to provide the information you need to reach next of kin in an emergency, to be attentive to allergies at a glance, and to tend to the client with care. See *Film Clip A.1* of a nurse conducting an assessment of a client's demographic and biographic data. See *Table A.1* for suggested questions and statements you can use to collect this data in an inclusive and caring manner, as well as an example of a demographic and biographic form below.



Watch: Demographic and Biographic Data

Video: “Nursing OER: Health Assessment – Demographic and Biographic Data” by eCampusOntario [1:58] is licensed under a CC BY-SA 4.0 license. *Transcript and closed captions available on YouTube.*

Film Clip A.1: Nurse assessing demographic and biographic data (Keep in mind that it is best to just ask “What gender pronouns do you use?” as opposed to using the language “preferred pronouns.” **This video was created prior to the shift in language).**

Table A.1: Introductory information: Collecting demographic and biographic data

Data	Questions and Statements
Name/contact information and emergency information	• What is your full name? • What name do you prefer to be called by? • What is your address? • What is your phone number? • Who can we contact in an emergency? What is their relationship to you? What number can we reach them at?
Birthdate and age	• What is your birthdate? • What is your age?
Gender	• Tell me what gender you identify with. • Not everyone uses a gender pronoun, but if you do, what gender pronouns do you use? (If the person asks you to use a pronoun that you are not familiar with, it is okay for you to respectfully respond, "I am not familiar with that pronoun. Can you tell me more about it?")
Allergies	• Do you have any allergies? • If so, what are you allergic to? • How do you react to the allergy? • What do you do to prevent or treat the allergy? Note: You may need to prompt for information on medications, foods, etc.
Languages spoken and preferred language	• What languages do you speak? • What language do you prefer to communicate in (verbally and written)? Note: You may need to inquire and document if the client requires an interpreter.
Relationship status	Tell me about your relationship status. Note: Avoid questions such as "Are you married?" or "Do you have boyfriend?" or "Do you have a wife?" as they assume normative behaviour and heterosexuality.
Occupation/school status	• What is your occupation? Where do you work? • Do you go to school? Note: Reassure the client that this information provides insight into the nature of their work (e.g., the physical or mental impact) and environmental exposures, and that the question is not intended to evaluate the client.
Resuscitation status	• We ask all clients about their resuscitation status, which refers to medical interventions that are used or not used in the case of an emergency (such as if your heart or breathing stops). You may need more time to think about this, and you may want to speak with someone you trust like a family member or friend. You should also know that you can change your mind. At this point, if any of this happens, would you like us to intervene? Note: Depending on the client's answer, you will need to collaborate with the broader healthcare team, explore the details of the client's wishes further, and have them complete a requisite resuscitation form.



Demographic Information Form (Example)

Demographic Information Form (Example)

Clicking the hyperlinked question mark (?) next to the example form fields will take you to some suggested questions to ask your patient.

Interview Date: _____

Client Name: _____ (?)

Date of Birth: _____ (?)

Age: _____ Sex: Male / Female / Another Option _____

Gender You Self-Identify With: _____ (?) Pronouns: _____

Healthcard Number: _____

Primary Language: _____ (?)

Relationship Status: _____ (?)

Phone Number:

Address:

Allergies: _____ (?)

Occupation/Education: _____ (?)

Resuscitation Status: (?)

Emergency Contact:

Relationship to Patient:

Phone Number:

Information from: Patient / Other

Patient Accompanied: Yes / No

Accompanied's Details:



Activity: Test Your Understanding

Quiz Text Description

1. MultiChoice Activity

Which question is part of the demographic/biographic assessment?

- a. What allergies do you have?
- b. Do you exercise?
- c. Have you been sick recently?
- d. Do you have children?
- e. What are your hobbies?

2. MultiChoice Activity

Which question is framed in an inclusive manner?

- a. Do you speak English?
- b. What name do you prefer to be called by?
- c. Are you married?
- d. Do you identify as female?

Solution:

1. a. What allergies do you have?
2. b. What name do you prefer to be called by?

A.2 Main Health Needs (Reasons for Seeking Care)

The client's main health needs are referred to in a variety of ways depending on the environment or institution in which you work. At the first point of contact, "main health needs" are often referred to as "*reasons for seeking care*" or "main concerns or issues." In an institution where the client is already admitted, "*main health needs*" is more commonly used.

Whichever term is used, it recognizes that clients are complex beings, with potentially multiple co-existing health needs, and that there is often a pressing issue requiring the most immediate care. This is not to suggest that other issues be ignored, but rather it allows providers, clients, and care partners to stay focused.

Most often, providers document the client's main health needs in the client's own words. *Table A.2 presents example questions* to determine a client's main health needs in different scenarios, along with sample responses.



Clinical Tip

It is important to avoid asking questions that begin with "why," which may suggest to the client that they did something wrong or that they are to blame for what is happening to them.

Table A.2: Determining main health needs (reasons for seeking care)

Client	Assessment	Sample Responses
Presenting to a clinic or a hospital emergency or urgent care (first point of contact).	Tell me about what brought you here today. Probes • Tell me more. • How is that affecting you?	• "I have a rash" • "I have been feeling quite depressed lately" • "I'm having pain"
Already admitted, and you are starting your shift.	Tell me about your main health concerns today. Probes • Tell me more. • How is that affecting you?	• "When will I be discharged?" • "I'm really hungry, can I eat something today?"

Take Action

As a health professional, you need to identify whether a client's symptomology is *normal*, *abnormal*, or requires intervention, or a *critical finding* that requires prompt intervention. Your subjective data assessment may be cut short if critical findings arise that require immediate intervention. In such a case, you focus on the critical finding and resume the complete subjective health assessment later, when appropriate. Some findings, even though normal, will require *health promotion* interventions.

Examples of subjective data that are identified as *critical findings* and require *prompt intervention* include, but are not limited to:

- Chest pain.
- Severe difficulty breathing.
- Sudden change in vision or ability to speak.
- Sudden weakness or paralysis in a limb.
- Uncontrollable bleeding.
- Post-operative pain or vomiting not relieved by medication.
- Suicidal or homicidal ideation with a plan.

Points of Consideration

Door-handle Conversations

“Door-handle conversations” describe the situation of a client sharing something with a health professional just as they are about to leave the room (their hand is on the door handle as illustrated in Figure A.1). Often, it is at the last minute when clients gather the courage to speak about a health issue that they are embarrassed or feel ashamed about. It may be about something that is stigmatized or that they feel may be judged on. In these cases, it is important to make time for the client and listen in a non-judgmental manner.



Figure A.1: Door-handle conversation



Activity: Test Your Understanding

Text Description

Which question is the best to ask a client when they first arrive at the hospital?

- a. Why did you come to the hospital?
- b. Tell me about what brought you to the hospital?
- c. Is there something wrong with you today?
- d. Do you need to see a doctor?

Solution:

Correct answer(s): b. Tell me about what brought you to the hospital?

A.3 Current and Past Health

Understanding the client's *current and past health* is important and may provide an explanation or rationale for the client's current health status, as illustrated in *Figure A.3*. These data can also provide insight into health promotion needs and comorbidities. It is helpful to understand the current and past health profiles before assessing other aspects of health, as the information will inform subsequent questions.

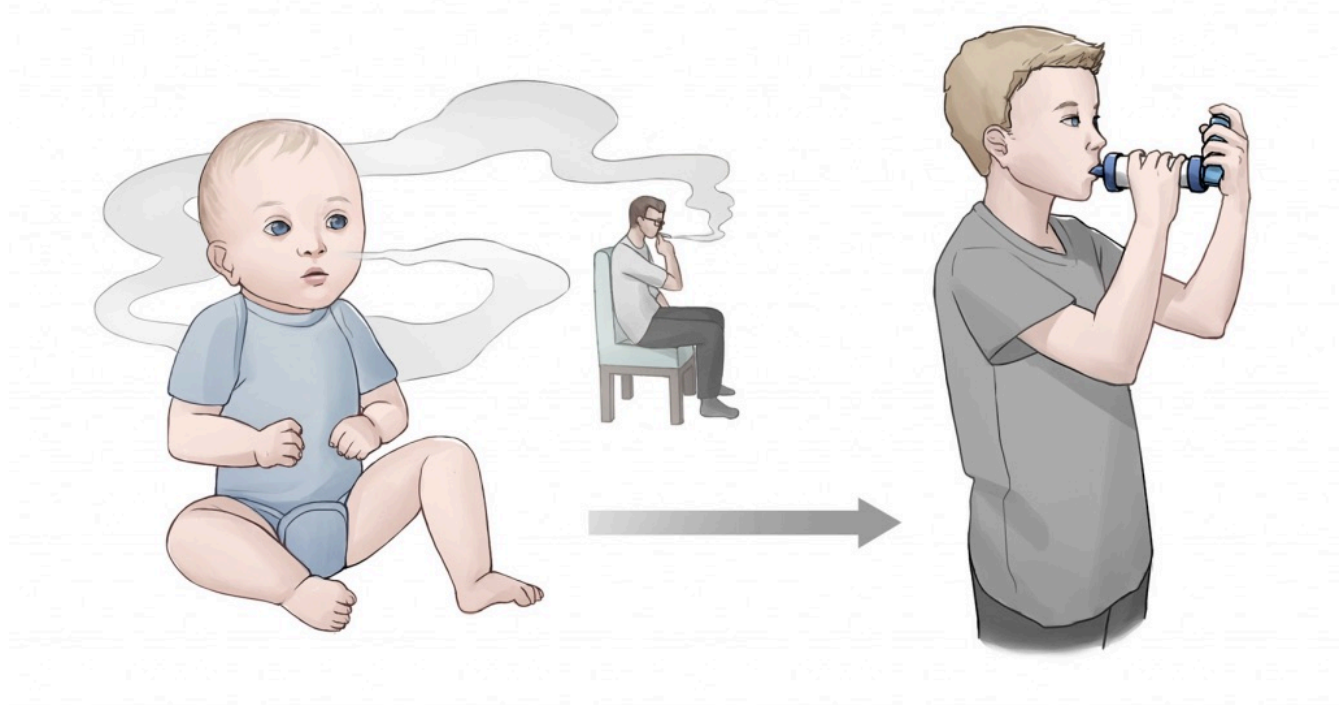


Figure A.3: The influence of past health on current health

The order of questions about current and past health, and the details elicited, often depend on the client's main health needs and developmental status. Not all questions apply to every client; their use and phrasing are contingent on the individual client and their situation.



Clinical Tip

Your questions should also be based on the client's response to the previous question.

As you develop your clinical judgment, which comes with practice, you will become more astute about *which questions are appropriate* and *how to frame* the questions. *Table A.3* provides sample questions for assessing

current and past health, but other questions may arise that you may need to ask depending on the client's main health needs and their responses.

Table A.3: Current and past health assessment

Health Items	Questions and Statements	Considerations
Current health Issues other than their previously noted main health needs/reasons for seeking care.	- Are there any other issues affecting your current health? Probes - Tell me more. - How is that affecting you?	Although the client may not have made the connection, other health issues are sometimes related to their main health need. For example, they may report a fever in addition to an earache.
Childhood illnesses Type, timing, treatment, hospitalizations, complications, disability	- Tell me about any significant childhood illnesses that you had. - When did it occur? - How did it affect you? - How did it affect your day-to-day life? - Were you hospitalized? Where? How was it treated? - Who was the treating practitioner? - Did you experience any complications? - Did it result in a disability?	The probing questions may be more important to ask when the illnesses may impact the client later in life.
Chronic illnesses Type, timing, impact, treatment, hospitalizations, complications, disability	- Tell me about any chronic illnesses you currently have or have had (e.g., cancer, cardiac, hypertension, diabetes, respiratory, arthritis). Probes - How has the illness affected you? - How do you cope with the illness? - When were you diagnosed? - Who was the treating practitioner? - How was the illness being treated? - Have you been hospitalized? Where? - Have you experienced any complications? - Has the illness resulted in a disability? - How does the illness affect your day-to-day life?	Chronic illnesses can significantly impact a client's life both physically and psychosocially.
Acute illnesses, accidents, or injuries Type, timing, treatment, hospitalizations, complications, disability	- Tell me about any acute illnesses that you have had. - Tell me about any accidents or injuries you currently have or have had. Probes - When did it occur? - Were you hospitalized? Where? - How was it treated? - Who was the treating practitioner? - Did you experience any complications? - Has it resulted in a disability? - How did it affect your day-to-day life?	Falls are an increasing health issue as a person ages or if they are taking several medications. This is partly related to decreases in muscle strength and balance and multimorbidity. It is important to assess the client's risk for falls and fall prevention. Check out the Registered Nurses' Association of Ontario (2017) best practice guideline: Preventing Falls and Reducing Injury from Falls
Obstetrical health Number of pregnancies, full-term deliveries, pre-term deliveries, number of living children, fertility treatments, miscarriages, abortions, and other data related to current or past pregnancy	- Have you ever been pregnant? - Do you have plans to get pregnant in the future? - Tell me about your pregnancies. - Have you ever had difficulty conceiving? - How was your labour and delivery? - Tell me about your postpartum experience. - Were there any issues or complications?	These questions do not apply to all clients. Additionally, you should be aware that the feelings about pregnancy can be complex and may not always be happy.



Clinical Tip

The parents or a care partner are often present during an assessment of an infant or child. The adult child or care partner is sometimes present during an assessment of an older adult, particularly if the client has an acute or chronic illness, or a cognitive impairment or a developmental delay. Care partners are important advocates in care planning. Thus, a family-centred approach can help you assess the client, as well as the level of caregiver burden and the need for additional resources.

Take Action

In addition to a comprehensive assessment, you should engage in *health promotion* discussions about a client's current and past health. For example, this may include helping the client to address any resolved issues associated with chronic and acute illnesses. Additionally, you should consider how the client can develop control over and improve their physical, mental, and social well-being. You should assess and discuss with them their social and personal resources to do so. Also, evaluate and intervene with critical findings related to current and past health that include anything that puts the *client's life at risk*.



Activity: Test Your Understanding

Quiz Text Description

1. MultiChoice Activity

Which question is most important to ask school-age children?

- a. Have you ever been pregnant?
- b. Do you have a disability?
- c. Tell me about any significant childhood illnesses?
- d. Have you been checked for hypertension?

2. MultiChoice Activity

A client tells you that they have been experiencing depression. What is your priority response?

- a. Are you taking any medications for it?
- b. Have you been hospitalized before?
- c. Have you seen a counsellor?
- d. Tell me about how it affects you.

Solution:

1. c. Tell me about any significant childhood illnesses?
2. d. Tell me about how it affects you.

A.4 Mental Health and Mental Illnesses

A client's mental health refers to their *emotional and psychological well-being*, which affects their day-to-day functioning. The World Health Organization (2014) defines mental health as a "state of well-being in which every individual realizes ... [their] own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to ... [their] community." Mental health is often under-screened, revealing a significant gap given that stress is pervasive in society.



Clinical Tip

Mental health is a component of every person—a state of well-being that fluctuates throughout life.

Mental illness includes conditions such as depression, anxiety, addiction, schizophrenia, and post-traumatic stress disorder, among others. By definition, *mental illness is a disruption in everyday function*, which means a person's employment, relationships, and civic participation can all be impaired by mental illness.

It is important to assess a client's mental health and, if present, mental illnesses. You want to begin this component of the assessment with a statement such as, "Mental health is an important part of our lives, and so I ask all clients about their mental health and any concerns or illnesses they may have."

See **Table A.4** for a selection of questions and statements that you may ask clients to elicit data about their mental health. Note also that there are many other factors that influence mental health, such as violence and trauma, which are addressed under the next section, Functional Health.

Table A.4: Mental health and illness assessment

Question or Statement	Considerations
Tell me about your mental health.	This question broadly focuses on health and invites a dialogue. The statement should not be asked in isolation, or as a one-off question, as societally and culturally there are different meanings of what constitutes mental health, and a client may not identify themselves as having mental health issues. If a client responds “Good,” consider probing a bit further with “Tell me about how so,” or “What do you mean by good?” which allows them to respond in more depth.
Tell me about the stress in your life.	Stress, by and large, is a relatable term that many clients have experienced, and that is something they are likely more comfortable talking about than more difficult health issues because it is so ubiquitous. It’s important to be attentive to the client’s language and consider terms they may use, such as “extreme stress,” “severe stress,” “unmanaged stress,” or “debilitating stress,” as these may indicate an underlying mental health issue or stress that requires intervention.
How does stress affect you?	Understanding how stress affects the client provides insight into the mental, physical, and social impact on them. You may need to probe about how stress affects the client physically, mentally, and socially.
How do you cope with this stress? (may include positive or negative coping strategies.)	This question invites discussion about coping strategies. It is important to be attentive to any self-harm coping strategies, such as substance abuse, isolation/disengagement, food restriction, purging, cutting, compulsions, and phobias, as these could indicate a mental health issue. Additionally, you want to use a <i>strength-based approach</i> to your assessment and facilitate the client’s capacity to identify and use positive coping strategies.
Have you experienced a loss in your life or a death that is meaningful to you?	Inviting discussions about loss and grief could be helpful for clients who have not had an outlet to speak openly about their emotions and the impact. Allowing for loss and grief to be talked about and understanding to what degree grief is affecting health is an important aspect of a mental health assessment.
Have you had a recent breakup or divorce?	Estrangement, emancipation, disruption, or severance of a relationship are not necessarily an indication of a mental illness. However, a pattern in relational disruption may indicate underlying issues such as, but not limited to, ineffective relationship skills, poor coping, or low self-esteem. Assess further if the client reports a breakup or divorce.
Have you recently lost your job or been off work?	Many clients define themselves through their work, and job loss can be disruptive to everyday life. Understanding the meaning of loss of employment is an important dimension of mental health.

Have you recently had any legal issues?	Asking about legal issues should be purposeful, not invasive. For example, a pattern of driving under the influence or possession of illicit drugs could indicate an underlying addiction. Use your clinical judgment when asking questions about legal issues, and be sure to convey an <i>unconditionally accepting way of being</i> with the client.
Have you purchased any weapons?	The purchase of weapons by itself is not an indication of mental illness. In Canada, some people enjoy hunting and other recreational activities that involve weapons. However, the purchase of weapons in response to threats to personal safety or to feelings of self-harm could indicate an underlying mental illness.

If the client identifies that they have a mental illness, you want to assess the onset of it and the associated impacts, treatments, hospitalizations, complications, and disabilities. Here are some questions and statements that you may use to elicit more information about the client's well-being in light of having a mental illness:

- How does that illness affect you?
- How does that illness affect your day-to-day life?
- How do you cope with the illness?
- What resources do you draw upon to cope with your illness?
- When were you diagnosed?
- Who was the treating practitioner?
- Have you been hospitalized? Where?
- Tell me about your treatment (e.g., medications, counselling).
- Have you experienced any complications?
- Has the illness resulted in a disability?
- Do you have any concerns that have not been addressed related to your illness?

Take Action

Health promotion is a vital component of all mental health assessments. You should collaborate with the client on how to develop healthy behaviours to promote their mental health. Also, chronic and sustained stress is an influencing factor of certain diseases, such as heart disease and cancer. Furthermore, some coping behaviours related to stress, such as using alcohol and cigarettes, can *exacerbate* the onset of these diseases. Thus, assessment and *collaborative interventions* **are** important.

You also need to be attentive to critical findings that require intervention. For example, if a client talks about feeling despair, hopelessness, or depression, it is important to *screen for suicidal thinking*. You should begin with a general probing question, such as “Have you ever felt like hurting yourself?” If the client responds with a “yes,” then you should progress with more exploratory and specific questions that assess the immediacy and the intensity of the feelings. For example, you may say, “Tell me more about that feeling. Have you been thinking about hurting yourself today? Have you put together a plan to hurt yourself?”

Points of Consideration

1. The client *most at risk* is one who has a specific plan about self-harm, specifying how and when, particularly if it is within 48 hours. The age of the client is not a factor in this determination. Under these circumstances, you should not leave the client alone. You should collaborate with them about an immediate emergency plan of care.
2. It is important that you not make assumptions about a client's mental health based on their appearance, facial expression, and capacity to function in their daily life. For example, you shouldn't assume that a person dressed nicely with a smile or neutral expression is mentally healthy or that a dishevelled person in a gown (see *Figure A.4*) has mental health issues.

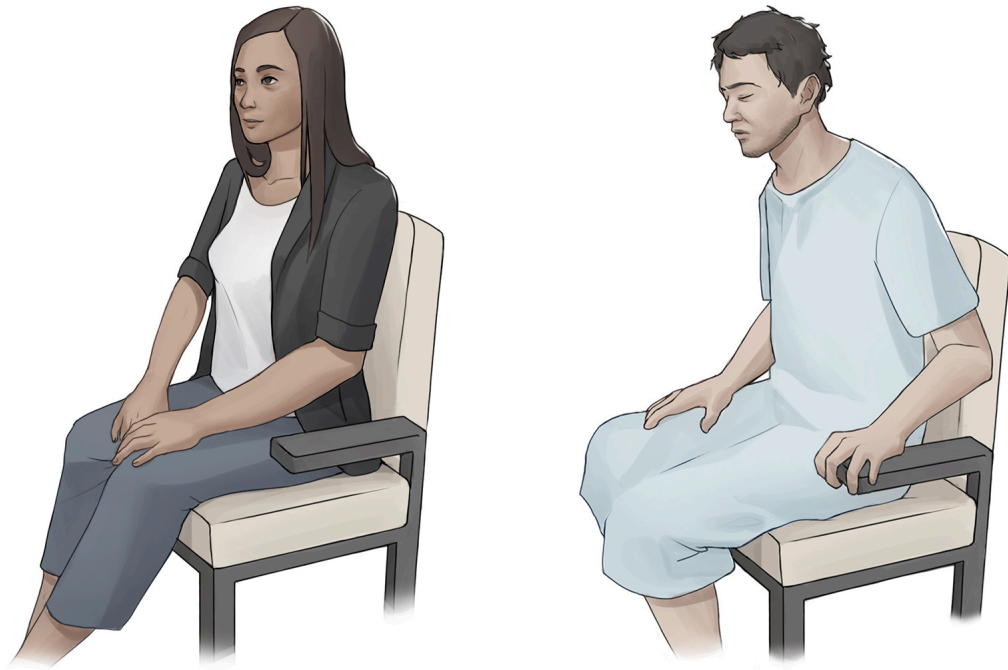


Figure A.4: To the left, a person sitting in a chair who is well-dressed and appears calm. To the right, a different person in a hospital gown is sitting in a chair, who appears to be distressed and in physical discomfort.

A.5 Functional Health

Functional health involves the assessment of the client's *physical and mental capacity to participate in day-to-day activities*. It includes assessment of:

- *Activities of Daily Living (ADL)*, as illustrated in *Figure A.5.1*, are daily basic tasks that are fundamental to everyday functioning (e.g., hygiene, elimination, dressing, eating, ambulating/moving).
- *Instrumental Activities of Daily Living (iADL)*, as illustrated in *Figure A.5.2*, are more complex daily tasks that allow clients to function independently (e.g., managing finances, paying bills, purchasing and preparing meals, managing one's household, taking medications, facilitating transportation). Assessment of iADL may be particularly important to inquire about with adolescents or young adults who have just moved into their first place, and clients who are older and/or have disabilities.

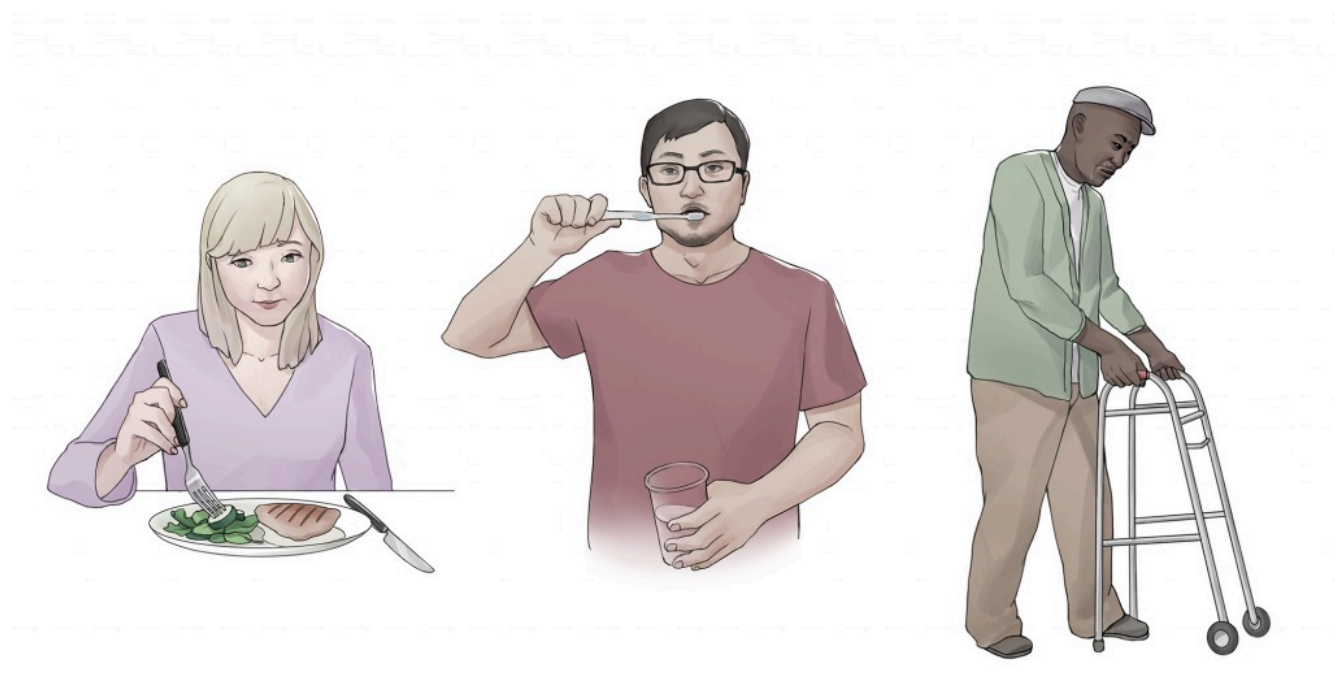


Figure A.5.1: From left to right: a person sitting at a table eating a meal, a person brushing their teeth, and an older person walking with a walker.



Figure A.5.2: From left to right: a person sitting at a table counting out pills and organizing their medication for the week, a person carrying a shopping basket and checking a shopping list, and an older person sitting at a table using a calculator as they pay bills.

It is important to assess functional health because the data collected could expose an opportunity for preventive action, health promotion, palliation, or assistance. Because *health extends beyond the absence of disease*, it is important to consider broader dimensions of health as a holistic and complete assessment.

You may start this section of the interview by saying, “Next, I would like to ask you some questions related to your day-to-day life and factors that affect your ability to function in your day-to-day life.” *Table A.5* outlines possible questions and statements to apply to the various sub-categories of functional health, along with some considerations. For interview demonstrations, see *Film Clip A.5.1* about elimination and *Film Clip A.5.2* about substance use.



Watch: Interview Demonstrations

Health Assessment – Elimination

Video A.5.1: “Nursing OER: Health Assessment – Elimination” by eCampusOntario [1:54] is licensed under a CC BY-SA 4.0 license. *Transcript and closed captions available on YouTube.*

Health Assessment – Substance Use

Video A.5.2: “Nursing OER: Health Assessment – Substance Use” by eCampusOntario [1:45] is licensed under a CC BY-SA 4.0 license. *Transcript and closed captions available on YouTube.*

Table A.5: Functional health assessment

Items	Questions and Statements	Considerations
Nutrition Refers to food and fluid intake, financial ability to purchase food, time and knowledge to prepare and make meals, and appetite or change in appetite. You also want to elicit data related to a client's usual diet and goals related to their nutrition. Additionally, you need to probe so that an adequate amount of detail is obtained. Take action This is an opportune time to engage in health promotion discussions about healthy eating. It is also important to be aware of risks for malnutrition and obesity, specifically assessing for patterns of rapid and excessive weight loss or weight gain.	• Tell me about your diet. • What foods do you eat? • What fluids do you drink? (Probe about caffeinated beverages, pop, and energy drinks.) • What have you consumed in the last 24 hours? Is this typical of your usual eating pattern? • Do you purchase and prepare your own meals? • Tell me about your appetite. Have you had any changes in your appetite? • Do you have any goals related to your nutrition? • Do you have the financial capacity to purchase the foods you want to eat? • Do you have the knowledge and time to prepare the meals you want to eat?	The types of questions asked and the level of detail required depend on the developmental age or health of the client. • Infants: Breast milk or formula, amount, frequency, supplements, problems and introductions of new foods. • Pregnant women: nutritional intake and presence of nausea and vomiting, intake of folic acid, iron, omega-3 fatty acids, vitamin D, and calcium. • Older adults or clients with disabling illnesses: Ability to purchase and cook their food, decreased sense of taste, ability to chew or swallow foods, loss of appetite, and enough fibre and nutrients.
Elimination Refers to the removal of waste products through the urine and stool. Healthcare providers refer to urinating as “voiding.” Stool is referred to as a “bowel movement.” You want to assess urine concentration, frequency, and odour. For stool, you want to assess frequency, colour, and consistency. You want to use terminology that clients understand. Thus, you may find yourself using less medicalized terms, such as “pee” and “poo” when speaking with some clients. Take action Findings that require further investigation include pain or difficulty upon urination, blood in the stool, melena (black, tarry stool), constipation, diarrhea, and excessive laxative use.	• How often do you urinate each day? • What colour is it (amber, clear, dark)? • Have you noticed a strong odour? • How often do you have a bowel movement? • What colour is it (brown, black, grey)? • Is it hard or soft? • Do you have any problems with constipation or diarrhea? If so, how do you treat it? • Do you take laxatives or stool softeners?	Toilet training takes several months, occurs in several stages, and varies from child to child. It is influenced by culture and depends on physical and emotional readiness, but most children are toilet-trained between 18 months and three years. Constipation and diarrhea are common symptoms associated with aging and medication usage. Thus, health promotion is needed in this area, particularly related to safe food preparation, drinking enough water, sufficient activity, and fibre intake (e.g., fruits and vegetables). Clients may experience nausea and abdominal pain with constipation and diarrhea.
Sleep and rest Refer to a client's pattern of rest and sleep and any associated routines or aids. Although it varies for everyone, it is suggested that people should get approximately eight hours of sleep per night. Take action Findings that require further investigation include disruptive sleep patterns and reliance on sleeping pills or other sedative medications.	• Tell me about your sleep routine. Probes • How much do you sleep? • Do you wake up at all? • Do you feel rested when you wake? • What do you do before you go to bed? (e.g., use the phone, watch TV, read) • Do you take any sleep aids? • Do you have any rest during the day?	Disruption in sleep patterns can occur across the lifespan. Assessing sleep patterns and routines will contribute to collaborative interventions. The use of social media and phones prior to bed can disrupt sleep patterns. Pain and stress can also disrupt sleep patterns.

Mobility, activity, exercise Mobility refers to a client's ability to move around (e.g., sit up, sit down, stand up, walk). Activity and exercise refer to informal and/or formal activity (e.g., walking, swimming, yoga, strength training). Note: In addition to exercise, it is important to assess activity because some people may not engage in exercise but still have an active living lifestyle (e.g., walking to school, working in a physically demanding job). Take action Findings that require further investigation include insufficient aerobic exercise and strength training, and an identified risk for falls.	• Tell me about your ability to move around. • Do you have any problems sitting up, standing up or walking? • Do you use any mobility aids (e.g., cane, walker, wheelchair)? • Tell me about the activity and/or exercise that you engage in. What type? How frequent? For how long?	The type of mobility and activity depends on the developmental age and the client's health and illness status. With infants, it is important to assess their ability to meet specific developmental milestones at each well baby visit. Mobility can become problematic for clients who are ill or are aging, and can result in self-care deficits. Thus, it is important to assess how their mobility is affecting their ADL.
Violence and trauma There are many types of violence, including abuse and neglect, physical, sexual, psychological, and financial. Trauma can be a result of violence or other distressing events in a person's life. Take action Collaborative intervention with the client is required when violence and trauma are identified. In Ontario, you are legally mandated to report suspected cases of child abuse or neglect to a children's aid society. You are also legally mandated to report suspected cases of elder abuse when the client resides in a long-term care or retirement home to the Ministry of Health and the long-term care director. You are also required to report to the College of Nurses of Ontario if you suspect that a nurse has abused or sexually abused a client. At any time, if you or the client is in immediate danger, call the police.	• Many clients experience violence or trauma in their lives. Can you tell me about any violence or trauma in your life? • How has it affected you? • Tell me about the ways you have coped with it. • Have you ever talked with anyone about it before? • Would you like to talk with someone?	People respond in different ways to trauma. It is important to use a <i>trauma-informed approach</i> when caring for clients who have experienced trauma. For example, a client may respond to the situation in a way that seems unfitting (such as laughter, ambivalence, or denial). This does not mean the client is lying; such a response could be symptoms of trauma. To reduce the effects of trauma, it is important to include social and psychological assessments of recent traumatic events (e.g., sudden loss, near-death experience, gravely ill child) and, more importantly, collaborative interventions to support clients experiencing trauma. The gendered and racialized experience of violence and trauma are important to assess. In addition to children, people with disabilities, and elderly people, there are other cohorts who are more at risk and respond to violence and trauma based on their identity.

Relationships and resources Refer to influential relationships in the client's life, whether positive or negative. Take action Findings that require further investigation include indications that a client does not have any meaningful relationships or has "negative" or abusive relationships in their lives. Sometimes the action involves providing a safe space for the client to talk about their experiences and working with them to identify goals.	• Tell me about the most influential relationships in your life. • Tell me about the relationships you have with your family. • Tell me about the relationships you have with your friends. • Tell me about the relationships you have with any other people. Probes • How do these relationships influence your day-to-day life? Your health and illness? • Who are the people that you talk to when you require support or are struggling in your life?	It is not the number of social contacts, but the social interconnectedness and meaning in relationships that is most important. Some clients can have a lot of social contacts but not describe any of them as meaningful. When clients feel isolated or lack meaning in their relationships, it can influence their physical and mental health, making them feel fatigued, sad or depressed, and make them eat more or eat less.
Intimate and sexual relationships Refer to sexual feelings, attractions, and preferences toward other people. It involves a combination of emotional connection and physical companionship (holding hands, hugging, kissing) and sexual activity. It is also linked with a person's identity and is part of their physical and mental health. Take action Assess further if a client describes, or if you observe, a partner who is controlling, reinforces stereotypical gendered roles (domineering), acts jealous or possessive, or has volatile moods. Although you are not legally responsible for reporting abuse in the adult context, it is important to fully assess and work with the client in developing a safety plan.	• I always ask clients about their intimate and sexual relationships. To start, tell me about what you think is important for me to know about your intimate and sexual relationships. • Tell me about the ways that you ensure your safety when engaging in intimate and sexual practices. • Do you have any concerns about your safety?	Gender is a social construction that exists along a continuum. It is a <i>way of being</i> with other people and not a binary. Gender is different than sexuality. It is important to be attentive to your language and expectations related to gendered roles within a relationship and not make assumptions about things such as who drives, who takes care of the children, or who earns the family income within a relationship.

Substance use Refers to the intake of alcohol, tobacco products (e.g., smoking, chewing tobacco), cannabis, or any illegal drugs (e.g., cocaine, heroin, meth, inhalants, fentanyl). Assess the type, frequency, quantity, and patterns, making a distinction between use and abuse. Substance misuse typically constitutes a disruption in everyday function because of a dependence on a substance (e.g., loss of employment, deterioration of relationships, loss of home or precarious living circumstances). Take action Action is needed if clients indicate that they have a problem with substance use or show signs of dependence, addiction, or binge drinking.	• To better understand a client's overall health, I ask everyone about substance use, such as tobacco, herbal shisha, alcohol, cannabis, and illegal drugs. • Do you or have you ever used any tobacco products (e.g., cigarettes, pipes, vaporizers, hookah)? If so, how much? • When did you first start? If you used to use, when did you quit? • Do you drink alcohol, or have you ever? If so, how often do you drink? • How many drinks do you have when you drink? • When did you first start drinking? If you used to drink, when did you quit? • Do you use or have you used any cannabis products? If so, how do you use them? How often do you use them? • When did you first start using them? • Do you purchase them from a regulated or unregulated place? • If you used to use cannabis, when did you quit? • Do you use any illegal drugs? If so, what type? How often do you use them? • Tell me about the ways that you ensure your safety when using any of these substances. • Have you ever felt you had a problem with any of these substances? • Do you want to quit any of these substances? • Have you ever tried to quit?	It is important to use a non-judgmental approach when assessing a client's use of substances so they feel accepted and not stigmatized. Substance use can affect people of all ages. Binge drinking is a health issue that sometimes affects adolescents and young adults. Also, use of some substances can influence the effectiveness of prescription medication.
Environmental health and home/occupational/school health Environmental health refers to the safety of a client's physical environment, which is a determinant of health. Examples include exposure to community violence, air pollution, and insect infestations. This may include health and safety in the school and workplace (e.g., hazardous materials, noise, body mechanics). Take action Findings that require further investigation include a client being exposed to unsafe environments. This includes prolonged exposure to second- and third-hand cigarette smoke, which is particularly hazardous for children (e.g., smoking in vehicles with children in the car).	• Tell me about any factors in your environment that may affect your health. Do you have any concerns about how your environment is affecting your health? • Tell me about your home. Do you have any concerns about safety in your home or neighbourhood? • Tell me about your workplace and/or school environment. • What activities are you involved in, or what does your day look like? Note: These questions will help you determine if probing, detailed questions are needed. For example, if a student or an office worker indicates they are on the computer most of the day, you may need to probe about ergonomics. If a client is working in a healthcare setting, you may need to probe about hazardous materials.	It is important to understand exposure to environmental hazards as nuanced. Not all exposure is the same. For example, during pregnancy, a client may be more attentive to environmental exposures. Some municipalities have banned pesticide use, as even small doses of exposure can have long-term health effects. It is important to ask about clean and safe water, more so in particular areas than others.

Self-concept and self-esteem Self-concept refers to all the knowledge a person has about themselves that makes up who they are (i.e., their identity). Self-esteem refers to a person's self-evaluation of these items as being worthy or unworthy. It is best to assess these items toward the end of the interview because you will already have collected data that potentially contributes to an understanding of the client's self-concept and self-esteem. Take action Findings that require further investigation include a client having low self-esteem, which can be inextricably related to mental health and wellness. Indeed, a criterion for diagnosing mental illness includes low self-esteem, which can contribute to illnesses such as depression and anxiety.	The factors that contribute to self-concept and self-esteem vary from person to person, so they are best assessed by using open-ended statements. You may need to prompt a client's responses by saying, "Tell me more" or "Please explain." • Tell me what makes you who you are. • Are you satisfied with where you are in your life? • Can you share with me your life goals?	The factors that influence a client's self-concept vary from person to person. Often these items involve valued elements of life such as talents, education, accomplishments, family, friends, career, stability, financial status, spirituality and religion.
Other iADL Refers to more complex daily tasks that allow clients to function independently. Take action Findings that require further investigation include the risk for falls in the home for clients with mobility limitations. These falls can occur while the client is trying to take care of their home (e.g., when cleaning or cooking). A previous history of falls is an important predictor of future falls. If the client reports a fall at home, brainstorm with them to identify hazards in the home (e.g., loose rugs, wet floors, socks without traction) and strategies for safety (e.g., mobility devices, removing tripping hazards, installing handrails).	• Tell me about how you take care of yourself and manage your home. • Do you have sufficient finances to pay your bills and purchase food, medications, and other needed items? • Do you have any current or future concerns about being able to function independently?	Avoid making assumptions about a client based on their age. It is important to maintain an optimistic view and work collaboratively with the client.



Activity: Test Your Understanding

Quiz Text Description

1. MultiChoice Activity

Insufficient money to buy food refers to:

- a. Instrumental activity of daily living (iADL)
- b. Activity of daily living (ADL)

2. MultiChoice Activity

Which question/statement is most appropriate to ask a three-year old child?

- a. Tell me about your bowel movement.
- b. Did you have a poop?
- c. Did you void this morning?
- d. Was your stool hard or soft?

3. MultiChoice Activity

The client indicates experiencing occasional constipation. What is your priority response?

- a. Ask them about any diarrhea
- b. Ask them to tell you more about the constipation
- c. Encourage them to eat more vegetables
- d. Develop a collaborative intervention that includes increased intake of fibre

4. MultiChoice Activity

Identify the critical findings (select all that apply):

- a. A client who has fallen twice in the past two months and reports recent weakness in left leg
- b. A client who describes their relationship with their spouse as the most meaningful relationship in their life.
- c. A client who has a bedtime routine consisting of a warm bath, soft music, and stretching.
- d. A client who reports difficulty seeing that just began in the last 5 minutes
- e. A client who manages their low self-esteem with exercise, healthy eating, and caring for a pet.
- f. A client who lives and works on farm.

Solution:

1. a. Instrumental activity of daily living (iADL)
2. b. Did you have a poop?
3. b. Ask them to tell you more about the constipation

4. a. A client who has fallen twice in the past two months and reports recent weakness in left leg; d. A client who reports difficulty seeing that just began in the last 5 minutes;

A.6 Preventative Treatments and Examinations

Assessing for other *preventive treatments and examinations* includes gathering data on medications, examination and, diagnostic tests, and vaccinations. See *Table A.7* for sample questions and statements, along with specific considerations. You might begin this section by asking the client, “What are the ways that are most important for you to optimize your health?” (You may have already discussed this as part of the functional health section.

It is important to ask the client about their current, past, and known future medication regimen, examinations, and immunizations to form a profile of the treatment that the client has received and plans to receive. This information will tell you a lot about the client’s current health status based on the care they have received and will receive.

Note: The client may refer to items that have already been discussed as part of the functional assessment or other items not yet discussed. You may need to probe with statements such as, “Tell me more,” and “How does that affect you?”

Table A.6: Preventive treatments and examinations

Items	Questions and Statements	Considerations
Medications Name, dose, frequency, reason for taking it, when they first started taking it, and whether they take it as prescribed. This applies to both prescribed and over-the-counter medications, such as vitamins, pain relievers, homeopathic medicines, and cannabis. Take action Medication misuse refers to taking medications outside their prescribed purpose. It can include snorting or injecting medications or taking excessive (large) non-prescribed dosages of medications such as opioids, sedatives, stimulants, and hypnotics. Assess further if you suspect medication misuse.	• Do you have the most current list of your medications? • Do you have your medications with you? (If not, you should ask them to list each medication they are prescribed and if they know the dose and frequency.) • Can you tell me why you take this medication? • How long have you been taking this medication? • Do you take the medications as prescribed? (If they answer “no” or “sometimes,” ask them to tell you the reasons for not taking the medications as prescribed.)	Some clients and their care partners are active in their care and will be able to answer all these questions. Other clients may not be able to answer all these questions, particularly in the context of <i>multimorbidity and polypharmacy</i>. Sometimes, clients do not take the medications as prescribed because they are experiencing adverse effects, have insufficient income to purchase the medications, and/or have received insufficient health promotion education and discussions when the medication was prescribed.
Examination and diagnostic dates Primary care provider (physician or nurse practitioner), specialists, blood pressure, blood tests, chest radiograph, electrocardiogram, dental, vision or hearing. (See Appendix A for a list of links to screening recommendations.) Take action Assess further if the client is an older adult who has never received any screening, such as blood pressure. It is important to explore with the client the reasons they have not received prior screening.	• When was the last time you saw [name the primary care provider, nurse or specialist]? • Can you share with me why you saw them? • When was the last time you had your [name screening] tested? • Do you know what the results were?	This is an opportune time for health promotion, particularly if you identify that examinations such as dental or vision have not been completed based on screening recommendations. Genetic screening during pregnancy is optional. In collaboration with their health professionals, some parents choose to screen for any abnormalities, and others do not. A finding of an abnormal result can be extremely difficult for some parents to experience, and some will decide not to act on such a result.

Vaccinations Type, date received, and any significant reactions (check the provincial or territorial immunization schedule). Immunization schedules for Ontario and immunization requirements for school attendance in Ontario can be found at Immunizations. Schedules for other provinces and territories are also available on the Internet. Take action Follow up on clients whose immunizations are not up-to-date.	• Can you tell me about your immunization status? • Can you tell me what immunizations you have had, the dates you received them, and any significant reactions? • Do you have your immunization record? • When was your last flu vaccine? If the client's immunizations are not up-to-date or if you noted vaccination hesitancy, you may ask: • Can you tell me the reasons that your immunizations are not up-to-date? • Can you tell me why you are hesitant to receive immunizations? (You may need to explore this further.) Depending on the client's age and main health needs/reasons for seeking care, you may ask about specific immunizations such as: • Tetanus if they have an injury or wound in which the skin is not intact. • Childhood vaccinations and adult boosters. Vaccines for older adults, such as influenza, pneumococcal, and shingles.	Vaccine hesitancy is a current global issue referring to the delay or refusal of vaccinations. Nurses and other health professionals play a vital role in addressing this issue. You should use a non-judgmental approach and work in partnership with your client to better understand their concerns. Using a relational inquiry approach will allow you to understand what is important to the client and, thus, be able to address existing knowledge gaps. Some clients who are immunocompromised cannot receive vaccinations. During times of outbreaks, they are at risk for exposure.
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Activity: Test Your Understanding

Quiz Text Description

1. MultiChoice Activity

Which statement or questions is most suitable when discussing vaccination hesitancy with a client?

- a. Tell me about your plans to send your child to school without vaccination.
- b. Tell me about the reasons you are not vaccinating.
- c. Why are you not vaccinating your child?
- d. Tell me about your travel plans.

2. MultiChoice Activity

Which statement or question is most suitable when addressing medication misuse?

- a. How do you know if you have taken too much of your medication?
- b. Why do you use that medication?
- c. Tell me about the intended purpose of your medication.
- d. Tell me about how you take your medication.

Solution:

- 1. b. Tell me about the reasons you are not vaccinating.
- 2. d. Tell me about how you take your medication.

A.7 Family Health

Assessing the current and past health of a client's family is important because diseases sometimes have a *genetic component*. These data provide you with a risk profile for inherited conditions. While it is important to understand the risk and likelihood of illness based on family health, these factors do not determine health and wellness. Sometimes health professionals construct genograms to document this information, as illustrated in *Figure A.7*. There are various ways to construct genograms; this is one example.

You want to ask questions that elicit information about the health status, age, and if applicable, cause of death and age at time of death of blood relatives (parents, grandparents, siblings, children, nieces, nephews). Questions to ask include:

- Tell me about the health of your blood relatives.
 - Do they have any chronic or acute diseases (e.g., cardiac, cancer, mental health issues)?
- Have any of your blood relatives died?
 - If so, do you know the cause of death?
 - And at what age did they die?

You also want to assess the health status of non-blood relatives and individuals that clients have had close encounters with or live with; this can be an important part of the assessment particularly in terms of *communicable diseases* (i.e., diseases spread through air, food, physical contact, contaminated surfaces, and insect and animal bites). Questions to ask include:

- Tell me about the health status of those you live with.
 - Has anyone been sick recently?
 - If so, do you know the cause?
 - What symptoms have they had?
- Have you been around anyone else who was sick recently (e.g., at work, at school, in a location that involved a close encounter, such as a plane or an office)?

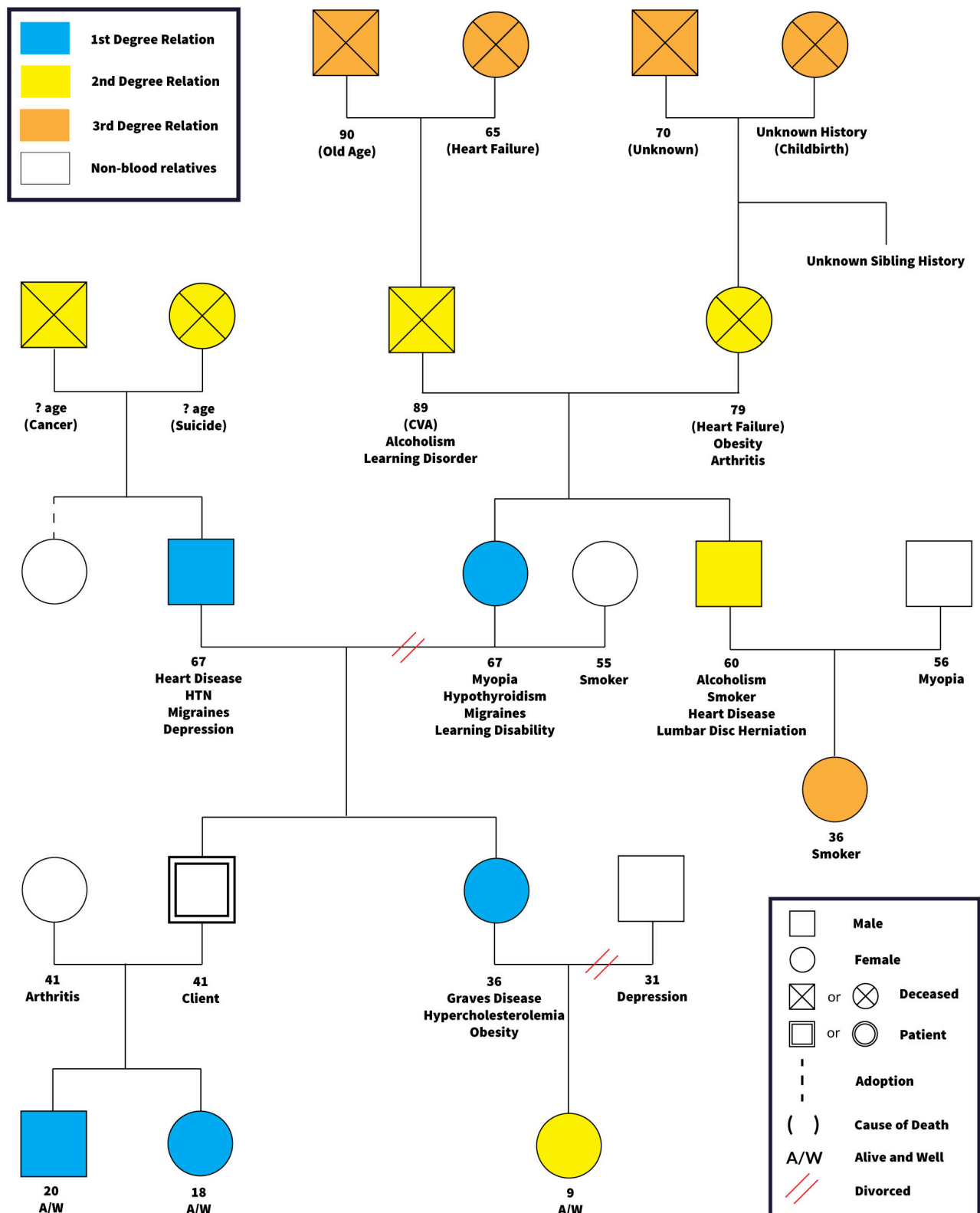


Figure A.7: A genogram for a 41-year-old client

Image Description

The image shows an example genogram, which is a family tree diagram that includes relationship patterns and health history across multiple generations.

A legend in the upper-left corner explains the colour coding:

- **Blue** represents a 1st degree relation.
- **Yellow** represents a 2nd degree relation.
- **Orange** represents a 3rd degree relation.
- **White** represents non-blood relatives.

A legend in the lower-right corner explains the symbols used in the genogram:

- A square represents a male.
- A circle represents a female.
- An X through a square or circle represents a deceased person.
- A double outline around a square or circle represents the patient or client.
- A dashed line represents adoption.
- Parentheses identify cause of death.
- **A/W** means alive and well.
- Two red diagonal lines across a relationship line represent divorce.

The genogram shows several generations of relatives and includes selected health information such as heart disease, heart failure, cancer, suicide, stroke/CVA, alcoholism, obesity, arthritis, myopia, hypothyroidism, migraines, learning disability, depression, Graves disease, hypercholesterolemia, smoking, and lumbar disc herniation.

The client is shown as a 41-year-old male with a double-outlined square. He is connected to family members, including parents, siblings, a partner, and children. The diagram uses connecting lines to show partnerships, parent-child relationships, sibling relationships, divorce, and adoption.

Points of Consideration

Many people seek genetic information to better understand their family health. This information may be available from genetic counsellors, who are health professionals who offer informational and supportive resources for persons seeking to better understand their genetic health history and risk for genetic disorders and inherited conditions. Also popular today are the DNA tests available commercially to determine family ancestry and health predispositions. Despite their popularity, the accuracy and privacy risks of this latter type of testing are questionable..



Activity: Test Your Understanding

Quiz Text Description

1. Blanks Activity

Family health includes questions related to people the client is ____ and ____.

2. MultiChoice Activity

What question best helps you assess a client's risk for communicable diseases?

- a. What did your same-sex parent die from?
- b. Have you received any genetic testing?
- c. How old were your parents when they died?
- d. Have the people you live with been ill recently?

Solution:

- 1. p>
Family health includes questions related to people the client is **related to** and **lives with**.
- 2. d. Have the people you live with been ill recently?

A.8 Cultural Health

Assessing cultural health involves gathering data on factors related to a *person's cultural background* that may influence their health and illness status.

An *open-ended question* allows the client to share what they believe to be most important. For example, you may ask, "I am interested in your cultural background as it relates to your health. Can you share with me what is important about your cultural background that will help me care for you?"

It is best to let clients spontaneously answer this question. Give them time to think. You should explore further any factors that they choose to share (e.g., "Tell me more." "How does that affect your health and illnesses?" "Is there anything else you want to share about how these factors act as resources in your life?")

Assessing cultural health once meant having a checklist about different cultural groups. This approach is antiquated because it assumes culture is static and measurable. It is important to encourage each client to speak about what is important to them. You may find that clients speak about information related to how they grew up and their way of life, their values and beliefs, traditions related to food, their spirituality or religion, among many other things.

Points of Consideration

It is important to let the client share their cultural health information without interruption or assumptions.

A.9 Developmental Considerations

A person's age needs to be considered when conducting the client interview. Most importantly, you need to consider a client's *developmental stage*. Developmental stage does not always align with a client's chronological age. With regard to communication, a focus on the developmental stage includes attention to areas such as language and cognitive and socio-emotional development. At times, you may need to modify your communication so that you are appropriately engaging with the client at a level they understand.

There are many ways to construct chronological age categories. Broadly, children are considered anyone under 18, and adults are considered anyone 18 and older. More specifically, you could consider the categories used in this resource:

- Newborns and neonates: newborns are born at a few hours old, and neonates are up to 28 days old.
- Young children: clients who are 5 years and younger, including infants (28 days to 1 year), toddlers (1–2 years), and preschoolers (3–5 years).
- Older children and adolescents: clients who are 6–17 years, including older children/school-age children (6–12 years) and adolescents (13–17 years).
- Adults and older adults: clients who are 18 years and older, including adults (18 years and older) and older adults (65 years and older).

See *Film Clip A.9* featuring an expert pediatric nurse discussing how communication varies between children and adults.



Watch: Communication Variations (Children Vs. Adults)

Film Clip A.9: Interview with an expert pediatric nurse. *Closed captions are not currently available.*

Transcript: Interview with an Expert Pediatric Registered Nurse

Interviewer: How does communication differ when working with children compared with adults?

Pediatric registered nurse: When working with children, it is very important to consider not only the child, but also the family member or caregiver who is present. The interaction is often with both the child and the caregiver, and the nurse needs to communicate with each of them in a way that helps the child feel safe.

Pediatric registered nurse: With children, I try to speak directly to them when possible and include them in the conversation. Even if the caregiver is providing most of the information, the child should still feel seen, included, and respected.

Pediatric registered nurse: Offering choices is also important. Children often have very little control in a healthcare setting, so giving them small choices can help. For example, you might ask whether they would like you to check their blood pressure on one arm or the other, or whether they would like to sit on the bed or on a caregiver's lap. The choices need to be real choices, but not choices about whether a required assessment or treatment will happen.

Interviewer: How do you consider developmental stage when communicating with children?

Pediatric registered nurse: Developmental stage is very important and may not always match chronological age. A child may be a certain age, but because of illness, stress, previous experiences, anxiety, or their current situation, they may communicate or respond at a different developmental level.

Pediatric registered nurse: I think about the child's language, vocabulary, cognitive ability, physical abilities, and social and emotional development. Some children need very simple explanations, some need extra time, and some need the help of a caregiver to understand what is happening.

Pediatric registered nurse: Children may also be frightened in the hospital or clinical environment. They may hide behind a caregiver, cry, refuse care, or appear upset. These responses can be normal, and it is important to remain calm, patient, and supportive.

Pediatric registered nurse: Using play, toys, pictures, or simple demonstrations can help. It can also help to explain what you are doing in concrete terms and to show the child the equipment before using it, when appropriate. For example, you might let the child look at or touch a stethoscope before you use it.

Pediatric registered nurse: Children may need reassurance, but it is important to be honest. If something may feel uncomfortable, the nurse should not say that it will not hurt. Instead, the nurse can explain what the child may feel and offer support, comfort, or distraction.

Interviewer: What about communicating with adolescents?

Pediatric registered nurse: With adolescents, it is important to recognize that they are developing independence and should be addressed directly. Caregivers may still be involved, but the adolescent should be treated as the client and given opportunities to speak for themselves.

Pediatric registered nurse: Privacy is especially important with adolescents. There may be times when the nurse asks the caregiver to step out so the adolescent can speak privately. This can be helpful when discussing sensitive topics such as substance use, sexuality, relationships, gender identity, mental health, or safety concerns.

Pediatric registered nurse: The nurse should explain why private time is being offered and should communicate in a respectful, non-judgmental way. Adolescents need to feel that they can speak honestly without being embarrassed or judged.

Pediatric registered nurse: At the same time, the nurse must also be clear about the limits of confidentiality, especially if there are concerns about harm, abuse, or neglect.

Interviewer: What role do caregivers play in pediatric communication?

Pediatric registered nurse: Caregivers are very important sources of information, especially for infants, young children, or children who are unable to explain what they are experiencing. Caregivers can help the nurse understand the child's usual behaviour, communication style, fears, routines, and needs.

Pediatric registered nurse: It is also important to support caregivers because they may be stressed or anxious. When caregivers understand what is happening and feel included, they are often better able to support the child.

Pediatric registered nurse: Overall, communication with children requires flexibility. The nurse needs to adapt language, tone, explanations, body language, and the level of caregiver involvement based on the child, the caregiver, and the situation.

APPENDIX B: HEALTH HISTORY REFERENCES



Appendix B Overview

- 3.1 Components of the General Survey (ASEPTIC)
- B.2 Components of a Nursing Health History
- B.3 Steps for Conducting a Health History Interview

B.1 Components of the General Survey (ASEPTIC)

A	Appearance & Behaviour
S	Speech
E	Emotion
P	Perception
T	Thought process
I	Insight
C	Cognition

Mental Status Examination (MSE)

What is the MSE?

The Mental Status Examination (MSE) is the psychiatric equivalent of the 'physical exam' in the Psychiatric Assessment.

The MSE are your observations from the patient encounter. Observations from the MSE are started from the moment you meet the patient and continue throughout the interview until the patient leaves.

Main Elements of the MSE (Mnemonic "ASEPTIC"):

1. A)PPEARANCE AND BEHAVIOUR

Apparent Age	Stated age? Younger/older?
Dress	Casually? Formally? Poorly?
Grooming	Good or poor?
Hygiene	Good or poor?
Gait	Brisk, slow, intoxicated, ataxic, rigid, shuffling, staggering, uncoordinated?
Psychomotor activity	Normal, reduced, excessive?
Abnormal movements	Grimaces, tics, tardive dyskinesia, foot tapping, ritualistic behaviour?
Eye contact	Good or poor?
Attitude	Cooperative, belligerent, oppositional, submissive, etc.?

2. S)PEECH

Rate	Rapid, pressured, slowed?
Rhythm	Hesitant, rambling, halting, stuttering, jerky, long pauses?
Tone of voice	Appropriate or inappropriate tone of voice?
Volume	Loud, soft, whispered, yelling, inaudible?
Accent	Any accent?
Clarity	Pronunciation, articulation
Quantity	Responds only to questions, offers information, repetitive, verbose?

3. E)MOTION (MOOD AND AFFECT)

Mood: Patient's subjective emotional state	When the clinician asks, "How is your mood?" and the patient responds, "Good", "Depressed", "Down", etc.
Affect: objective emotional state	What you actually observe about how they appear to be feeling, e.g. if their affect appears down, euphoric, etc.
Congruence to mood	Congruent mood means that the mood is appropriate to the situation, e.g., the patient's father has passed away, and the patient is sad
Appropriateness	Incongruent mood means that the mood is inappropriate to the situation, e.g., the patient's father has passed away, and the patient is laughing hysterically
Quality	Euthymic, elevated, depressed?
Range	Broad/ restricted?
Stability	Fixed / labile?

4. P)ERCEPTION

Hallucinations	Auditory: Are you hearing any things that others can't hear? Visual: Are you seeing any things that others can't hear? Olfactory: Any unusual smells that you notice, e.g. burning smells? (classically seen in temporal lobe epilepsy)
Illusions	Distortions of real images or sensations
Depersonalization	Patient feels that they are not real Clinician: "Do you ever feel that you are not real?"
Derealisation	Patient feels that the world is not real Clinician: "Do you ever feel that things around you aren't real?"

5. T)HOUGHT CONTENT AND PROCESS

Thought Process	How well are the patient's thoughts connected? Are the patient's thoughts coherent, logical, and relevant? Does the patient tend to go off topic? (e.g. circumstantial) Does the patient completely go from one thing to the next? (e.g. tangential (as in mania, psychoses); flight of ideas (as in mania, disconnecting rambling from one idea to the next); loosening of associations (as in psychosis with shifting from one subject to another) Thought blocking (as in psychosis, where a person stops suddenly in the middle of a sentence) Word salad (as in schizophrenia, with seemingly random words and phrases) Echolalia (as in Tourette's where the patient copies another's speech), Neologisms (as in psychosis, with the patient making up new words)
Thought Content	Description
Delusions	Delusions: (to friends and family): "Does your loved one have any strong or unusual beliefs?" Delusions: (to the patient) "Everyone has beliefs. Some people are religious. Some people believe in UFOs. Some people believe that the government is spying on us. Any strong beliefs that you have?" (NOTE: Having any of the above beliefs can be on the normal spectrum. It is when these beliefs are to an unhealthy extreme that causes problems, that one wonders about psychosis. E.g. On one hand, it is normal for many to believe in God. On the other hand, if one believes that God has given them special powers that allow them to jump off a building and fly, this would likely be delusional.) Paranoid delusions: "Do you feel that people are watching you, following you or trying to hurt you?" Delusions of grandeur: "Do you have any special powers or skills?"
Suicidal ideation	Suicidal: "With all the stress that you've been under, has it ever gotten to the point that you feel life isn't worth living?" If positive, then ask: "What's the strongest those thoughts have gotten?" "At this moment, do you have any thoughts of ending your life?"
Homicidal ideation	Homicidal ideation: "Any thoughts of hurting other people?"

6. I) INSIGHT AND JUDGEMENT

Insight	Assuming the patient has difficulties and/or an illness, does the patient understand this? • Good insight: Patient understands they are ill and need treatment (similar to being in action phase) • Partial insight may indicate that the patient acknowledges a problem, but is not willing to seek appropriate help or treatment (similar to being contemplative) • Poor insight means that the patient does not see that they are ill, nor does the patient need any help or treatment (similar to being pre-contemplative)
Judgment	Is the patient able to use facts and make reasonable decisions? May be good, fair, impaired

7. C) COGNITION

Level of consciousness	Alert, confused, lethargic, stuporous
Orientation in 3 spheres	Name: What is your name? Place: Where are you right now? Time: What year, month, day is it?
Attention/Concentration	How well does the patient seem to be able to focus? (Good, poor)
Memory	How well can the patient remember? Short-term: Can the patient recall recent things that have happened? Long-term: Can the patient recall distant events?
Intelligence (globally and intellectual functions)	Based on your observations and the patient's use of speech, does the patient's overall intelligence and cognition appear to be 1) below average, 2) average, or 3) above average?

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Abecassis, T., Aggarwal, D., & eMentalHealth.ca Primary Care Team. (2020, September 17). *Mental status examination (MSE)*. eMentalHealth.ca. <https://primarycare.ementalhealth.ca/index.php?m=fpArticle&ID=26974>.

B.2 Components of a Nursing Health History



Figure B.2: Components of a Health History. Image: content adapted from (Potter et al., 2019).

Image Description

- A. Biographical Data
- B. Source of History
- C. Reason for Seeking Care
- D. Current State of Health
- E. Past Health History
- F. Family Health History
- G. Functional Health & ADLs
- H. Developmental Variables
- I. Psychological Health

J. Socio-cultural & Spiritual Health

B.3 Steps for Conducting a Health History Interview

6 Steps for Conducting a Health History Interview

Orientation Phase of the Interview

Step #1

Gather supplies (health history form, patient chart or electronic record and pen)

Step #2

Knock, enter the room, greet the patient, and provide privacy

Step #3

Perform safety steps:

- Perform hand hygiene
- Check the room for transmission-based precautions.
- Introduce yourself, your role, the purpose of your visit and an estimate of the time it will take
- Confirm patient ID using two patient identifiers, such as name and date of birth
- Explain the process to the patient and ask if they have any questions
- Ensure the patient's privacy and dignity – review confidentiality of conversation and obtain consent
- Be organized and systematic
- Use appropriate listening and questioning skills
- Listen and attend to patient cues
- Assess ABCs (Airway, Breathing, and Circulation)

Working Phase of the Interview

Step #4

Address patient needs (pain, toileting, glasses/hearing aids) prior to starting:

- Note if the patient has signs of distress (e.g., difficulty breathing or chest pain).
- If signs are present, defer the health history and obtain emergency assistance following agency policy

Termination Phase of the Interview

Step #5

Ensure five safety measures before leaving the room:

- **CALL LIGHT:** Within reach
- **BED:** Low and locked (lowest position appropriate to the client and brakes on)
- **SIDE RAILS:** Secured and appropriate to the client's situation
- **TABLE:** Within reach
- **ROOM:** Risk-free for falls (scan room and clear any obstacles)

After you leave the patient's room, at the end of the termination phase, perform hand hygiene

Step #6

Document the health history findings and report any concerns according to agency policy

Adapted from "2: Health History," sections 2.5–2.8, 2.11, in *Nursing: Mental Health and Community Concepts* by Ernstmeyer & Christman (Eds.), which is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

APPENDIX C: COMPLEX COMMUNICATION



Appendix C Overview

C1: Impaired Hearing and Vision Strategies

C2: Strategies for Clients with Impaired Speech

C1: Impaired Hearing and Vision Strategies

Strategies for Communicating with Clients with Impaired Hearing and Vision

Impaired Hearing

- Gain the client's attention before speaking (e.g., through touch)
- Minimize background noise
- Position yourself 2-3 feet away from the client
- Facilitate lip-reading by facing the client directly in a well-lit environment
- Use gestures when necessary
- Listen attentively, allowing the client adequate time to process communication and respond
- Refrain from shouting at the client
- Ask the client to suggest strategies for improved communication (e.g., speaking toward a better ear and moving to a well-lit area)
- Face the client directly, establish eye contact, and avoid turning away mid-sentence
- Simplify language (i.e., do not use slang but do use short, simple sentences), as appropriate
- Note and document the client's preferred method of communication (e.g., verbal, written, lip-reading, or American Sign Language) in the plan of care
- Assist the client in acquiring a hearing aid or assistive listening device
- Refer to the primary care provider or specialist for evaluation, treatment, and hearing rehabilitation

(Clark et al., 2022)

Impaired Vision

- Identify yourself when entering the client's space
- Ensure the client's eyeglasses or contact lenses have a current prescription, are cleaned, and stored properly when not in use
- Provide adequate room lighting
- Minimize glare (i.e., offer sunglasses or draw window covering)
- Provide educational materials in large print
- Apply labels to frequently used items (i.e., mark medication bottles using high-contrast colours)
- Read pertinent information to the client
- Provide magnifying devices
- Provide referral for supportive services (e.g., social, occupational, and psychological)
- Identify item locations on a meal tray using the clock method. For example, the nurse states, "Your milk is at 2:00, the potatoes are at 3:00, and the meat is at 9:00. on your plate."

(Clark et al., 2022)

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C2: Strategies for Clients with Impaired Speech

Improving Communication for Clients with Impaired Speech

Impaired Speech

- Modify the environment to minimize excess noise and decrease emotional distress
- Phrase questions so the client can answer using a simple “Yes” or “No,” being aware that clients with expressive aphasia may provide automatic responses that are incorrect
- Monitor the client for frustration, anger, depression, or other responses to impaired speech capabilities
- Provide alternative methods of speech communication (e.g., writing tablet, flash cards, eye blinking, communication board with pictures and letters, hand signals or gestures, and computer)
- Adjust your communication style to meet the needs of the client (e.g., stand in front of the client while speaking, listen attentively, present one idea or thought at a time, speak slowly but avoid shouting, use written communication, or solicit family’s assistance in understanding the client’s speech)
- Ensure the call light is within reach and the central call light system is marked to indicate the client has difficulty with speech
- Repeat what the client said to ensure accuracy
- Instruct the client to speak slowly
- Collaborate with the family and a speech therapist to develop a plan for effective communication

(Wagner et al., 2024)

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APPENDIX D: VITAL SIGNS



Appendix D Overview

D1: Vital Signs Checklist I

D2: Vital Signs Checklist II

D3: Checklist for Blood Pressure

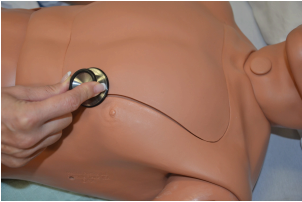
D1: Vital Signs Checklist I

Temperature, pulse, respiration, blood pressure (BP), and oxygen saturation are measurements that indicate a person's hemodynamic status. These are the five vital signs most frequently obtained by health care practitioners (Perry, Potter, & Ostendorf, 2014). Vital signs will potentially reveal sudden changes in a patient's condition and will also measure changes that occur progressively over time. A difference between patients' normal baseline vital signs and their present vital signs may indicate the need for intervention (Perry et al., 2014). *Checklist D1* outlines the steps to take when checking vital signs.

Disclaimer:

Always review and follow your hospital policy regarding this specific skill.

Checklist D1: Vital Signs

Steps	Additional Information
1. Temperature:  <i>Taking temperature</i>	Normal (oral) = 35.8°C to 37.3°C Oral temperature: Place the thermometer in the mouth under the tongue and instruct the patient to keep the mouth closed. Leave the thermometer in place for as long as is indicated by the device manufacturer. Axillary temperature: Usually 1°C lower than oral temperature. Place the thermometer in patient's armpit and leave it in place for as long as is indicated by the device manufacturer. Tympanic membrane (ear) temperature: Usually 0.3°C to 0.6°C higher than an oral temperature. The tympanic membrane shares the same vascular artery that perfuses the hypothalamus. Do not force the thermometer into the ear and do not occlude the ear canal. Rectal temperature: Usually 1°C higher than oral temperature. Use only when other routes are not available.
2. Pulse: Normal resting heart rate = 60 to 100 beats per minute  <i>Radial pulse</i>  <i>Apical pulse</i>	Radial pulse: Use the pads of your first three fingers to gently palpate the radial pulse at the inner lateral wrist. Apical pulse: Taken as part of a focused cardiovascular assessment, and when the pulse rate is irregular. Apical heart rate should be used as the parameter indicated in certain cardiac medications (e.g., digoxin). Apical pulse rate should be taken for a full minute for accuracy, and is located at the fifth intercostal space in line with the middle of the clavicle in adults. Carotid pulse: May be taken when the radial pulse is not present or is difficult to palpate.

3. Respiration rate: Normal resting respiratory rate = 10 to 20 breaths per minute  <i>Respiratory rate</i>	Count the respiratory rate unobtrusively while you are taking the pulse rate so that the patient is not aware that you are taking the respiration rate. Count for 30 seconds or for a full minute if irregular.
4. Blood pressure (BP):  <i>Blood pressure cuff</i> The average BP for an adult is 120/80 mmHg, but variations are normal for various reasons.	The systolic pressure is the maximum pressure on the arteries during left ventricular contraction. The diastolic pressure is the resting pressure on the arteries between each cardiac contraction. The patient may be sitting or lying down with the bare arm at heart level. Palpate the brachial artery just above the antecubital fossa medially. Wrap the BP cuff around the upper arm about 2.5 cm above the brachial artery. Palpate the radial or brachial artery, and inflate the BP cuff until the pulse rate is no longer felt. Then inflate 20 to 30 mmHg more. Place the bell of the stethoscope over the brachial artery, and deflate the cuff slowly and evenly, noting the points at which you hear the first appearance of sound (systolic BP), and the disappearance of sound (diastolic BP).
5. Oxygen saturation (SpO₂): A healthy patient will have an SpO₂ of ≥ 97%.  <i>Pulse oximeter sensor</i>	A pulse oximeter sensor attached to the patient's finger or earlobe measures light absorption of hemoglobin and represents arterial SpO₂.
Data source: Jarvis et al., 2014; Stephen, Skillen, Day, & Jensen, 2012	



Critical Thinking Exercises

1. Which type of thermometer is the best example of a non-invasive, safe, and efficient tool for measuring temperature?
2. A 40-year-old male patient has a blood pressure of 140/100 mmHg. Is this normal for this patient? What additional data would you need to collect before making a decision about this patient's care?

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D2: Vital Signs Checklist II

Disclaimer

Always review and follow agency policy regarding the following specific skills listed in these checklists.

Checklist for Vital Signs

Step #1

Knock, enter the room, greet the patient, and provide for privacy.

Step #2

Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.

Step #3

Perform hand hygiene and clean the stethoscope before approaching the patient.

Step #4

Ask the patient for their name and date of birth for the first identifier and verify wristband while the patient is stating information. Then use one of the following for the second identifier:

- Scan wristband
- Compare name/DOB to MAR
- Ask staff to verify patient (LTC setting)
- Compare the picture on MAR to the patient

Step #5

Explain the procedure to the patient; ask if they have any questions.

Step #6

Obtain temperature using the correct technique in Celsius. Inform the instructor if the temperature is out of range. Normal range: 98.6 F or 37 C.

Step #7

Obtain an accurate pulse using the radial artery. Inform the instructor if the pulse is out of range. Normal range for a pulse in an adult: 60-100 with regular rhythm.

Step #8

Obtain an accurate respiratory rate over 60 seconds. Inform the instructor if the respiratory rate is out of range. Normal range for respiratory rate in an adult: 12-20.

Step #9

Obtain oxygen saturation reading (SpO₂) using a pulse oximeter. Inform the instructor if SpO₂ is out of range. Normal range for SpO₂: 94-100%.

Step #10

Ensure safety measures when leaving the room:

- CALL LIGHT: Within reach
- BED: Low and locked (in lowest position and brakes on)
- SIDE RAILS: Secured
- TABLE: Within reach
- ROOM: Risk-free for falls (scan room and clear any obstacles)

Step #11

Perform hand hygiene and clean the stethoscope.

Step #12

Follow the agency policy for following up on vital signs outside of normal range.

Step #13

Document vital signs.

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D3: Checklist for Blood Pressure

Use the checklist below to review the steps for obtaining a “Manual Blood Pressure.”

Note:

The two-step method includes inflating the cuff and palpating the radial pulse to estimate systolic blood pressure before obtaining the blood pressure reading. This procedure is based on current AHA recommendations (Chobanian et al., 2003).



Watch: Assessing Blood Pressure

View an instructor demonstration YouTube video on assessing blood pressure.

Video: “Assessing Blood Pressure” by WisTech Open | Open RN [4:36] is licensed under the Standard YouTube License. *Transcript and closed captions available on YouTube.*

Steps

Disclaimer: Always review and follow agency policy regarding this specific skill.

Step #1

Gather supplies: blood pressure cuff and stethoscope. (Select an appropriately sized cuff for the patient.)

- The width of the cuff should be 40% of the person's arm circumference, and the length of the cuff's bladder should be 80–100% of the person's arm circumference.

Step #2

Perform safety steps:

- Perform hand hygiene.
- Check the room for transmission-based precautions.
- Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.
- Confirm patient ID using two patient identifiers (e.g., name and date of birth).
- Explain the process to the patient and ask if they have any questions.
- Be organized and systematic.

- Use appropriate listening and questioning skills.
- Listen and attend to patient cues.
- Ensure the patient's privacy and dignity.
- Assess ABCs.

Step #3

Cleanse the stethoscope and blood pressure cuff prior to placing it on the patient's skin.

Step #4

Place the patient in a relaxed reclining or sitting position. The patient should be seated quietly for at least 5 minutes before blood pressure measurement. Ask the patient which arm they prefer to use. Be aware of conditions that contraindicate the use of an arm for blood pressure measurement, such as a previous mastectomy or the presence of a fistula. During the procedure, both feet should be on the floor, and the arm should be supported at heart level.

- Adapt the procedure to the life span considerations of the patient.

Step #5

Remove or rearrange clothing so the cuff and the stethoscope are on bare skin.

Step #6

Center the bladder of the blood pressure cuff over the brachial artery with the lower margin 1" above the antecubital space. Fit the cuff evenly and snugly. Palpate the brachial artery in the antecubital space.

Step #7

Locate the radial pulse.

Step #8

Inflate the cuff rapidly (while palpating the radial or brachial pulse) to the level at which pulsations are no longer felt, and inflate the cuff 30 mmHg above the palpated pressure or the patient's usual blood pressure. Note the level and rapidly deflate the cuff; wait 30 seconds.

Step #9

With the eartips of the stethoscope placed downward and forward, place the bell/diaphragm lightly on the brachial artery and rapidly inflate the cuff to 30 points above where the brachial or radial pulse is no longer felt.

Step #10

Deflate the cuff gradually at a constant rate by opening the valve on the bulb (2-3 mm Hg/second) until the first Korotkoff sound is heard. Note the systolic pressure.

Step #11

Continue to deflate the cuff slowly at 2 mm Hg/second. Note the point at which Korotkoff sounds disappear completely as the diastolic pressure.

Step #12

Deflate the cuff completely and remove the cuff from the patient's arm.

Step #13

Inform the patient of the blood pressure reading.

Step #14

Cleanse the stethoscope and blood pressure cuff.

Step #15

Perform proper hand hygiene.

Step #16

Ensure safety measures when leaving the room:

- CALL LIGHT: Within reach
- BED: Low and locked (in lowest position and brakes on)
- SIDE RAIL: Secured
- TABLE: Within reach
- ROOM: Risk-free for falls (scan room and clear any obstacles)

Step #17

Document findings and report significant deviations from norms according to agency policy.

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