
INTRODUCTION TO THE CLINICAL PRACTICE GUIDELINES

First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines for Nurses in Primary Care.
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PURPOSE

The *First Nations Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care* are practice tools designed to support community health nurses' clinical decisions when delivering primary health care within First Nations and Inuit communities. As an educational tool, the guidelines aim to support nursing practice for pediatric, adolescent and adult clients.

The guidelines are based on best practices and evidence available at the time they were written. They are to be used in concert with regional and/or national guidelines, as well as the *First Nations Inuit Health Branch Formulary* and *Drug Classification System*, the latter in regions where it is used.

The guidelines provide a broad range of topics and health conditions aimed at complementing individual nurses' self-assessment of knowledge, skills and judgment and do not necessarily represent provincially legislated scope of practice. In regions where a transfer of authority is recognized by regulatory bodies, the guidelines grant the registered nurse employed by Health Canada, limited authority to diagnose, request diagnostic tests (for example, laboratory tests and diagnostic imaging), and treat clients as per each health condition included in the guidelines. Provincial regulations, regional decisional support tools, protocols, transfer of function or delegation tool may supersede this authority.

STRUCTURE

The *First Nations Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care* are set up in a specific manner to make it easier for the users of the guidelines. The majority of the chapters in the guidelines are based on a specific body system and then present the more common and associated medical diagnoses/conditions. These chapters use the formats that follow.

FORMAT OF BODY SYSTEM CHAPTERS

Each chapter that corresponds to a body system is set up in the following format:

Assessment of the Body System

- Cardinal Symptoms (in some chapters)
- History of Present Illness and Review of Systems
- Physical Examination

Common Problems of the Body System

- Conditions

Emergencies for the Body System

- Conditions

FORMAT OF MEDICAL DIAGNOSIS/CONDITION DESCRIPTIONS

The chapters that describe medical diagnoses/conditions describe each condition by using the following headings (if applicable to the condition):

Medical Diagnosis/Condition

- Causes
- History
- Physical Findings
- Differential Diagnoses
- Complications
- Diagnostic Tests
- Management
 - Goals of Treatment
 - Appropriate Consultation
 - Adjuvant Therapy
 - Nonpharmacologic Interventions
 - Pharmacologic Interventions
 - Monitoring and Follow-Up
 - Referral
 - Prognosis (present occasionally)

CULTURE^{1,2,3,4}

Culture refers “to shared patterns of learned behaviours and values that are transmitted over time, and that distinguish the members of one group from another.... [It] can include: ethnicity, language, religion and spiritual beliefs, gender, socio-economic class, age, sexual orientation, geographic origin, group history, education, upbringing and life experiences”.⁵ Each individual First Nations and Inuit community has their own specific culture which includes traditional and/or Western practices. They are diverse.

The *Inuit Way: A Guide to Inuit Culture* can serve as an introduction to Inuit culture⁶ (available at: http://pauktuutit.ca/pdf/publications/pauktuutit/InuitWay_e.pdf).

COMMONLY CITED VALUES⁶

Mainly for purposes of illustration, some commonly cited values of First Nations and Inuit people are given below. It must be emphasized that these values do not necessarily hold true for all First Nations and Inuit people and/or communities, but they do alert the healthcare practitioner to the kinds of differences that can exist and to the possible consequences, for both understanding the client and providing a health service, if these differences are not recognized.

NON-INTERFERENCE

A high degree of respect for a person’s independence leads to the view that giving instructions, coercing or even persuading another person, including a child, is inappropriate. This ethic may be perceived by another culture as apathy, neglect, indifference, lack of social responsibility or evasiveness.

ANGER

Displays of anger could jeopardize the voluntary cooperation essential to survival of a close-knit group. Hostility must be suppressed. It has been suggested that this practice may lead to a particular vulnerability to depression.

TIME

Time is a personal, flexible concept and is not related to the clock so much as to feeling ready to act.

SHARING

Group survival is more important than personal prosperity. Sharing assures the survival of the group.

COOPERATION

Competition can interfere with group cohesiveness. Cooperation increases the sense of solidarity and pools effort, talent and resources.

EXCELLENCE

Gratitude is rarely shown or verbalized because each individual is expected to behave at a “normal” (that is, excellent) level.

CULTURE AND HEALTH

Health beliefs and practices (traditional and/or Western) influence a client’s illness experience: how they define, understand and manage the health problem.

Health for many First Nations and Inuit individuals focuses on wholeness: achieving balance, strength and interconnectedness of body, mind, emotions, and spirit. Each person is also linked to the health of the environment (for example, plants, animals, earth, sky, water), community and family dependently and interdependently. First Nations and Inuit believe that they can only understand something if they understand how it is connected to everything else. This connection is why it is important to First Nations people to have others around when they are ill. One way some First Nations explain all of these elements and connections is through the medicine wheel. When one area (internally and/or externally) is not working well (for example, disease), the other aspects of health are also affected. Healing restores harmony and connections between all aspects of health: not just one part.

Traditional and cultural knowledge (often from lived experience) is collectively owned and exchanged and is often shared by Elders and healers in the community by storytelling. Two traditional healing practices used in some First Nations communities are smudging (to rid the body or space of negative energy and bring vision) and sweat lodges (for healing through cleansing body and mind, teaching, praying, singing and communicating). These direct the participant to look and direct their energy inward and credit relationships with the spirit world for healing. More information on traditional medicine is available in the document entitled *Traditional Medicine in Contemporary Contexts: Protecting and Respecting*

Indigenous Knowledge and Medicine (available at: http://www.naho.ca/documents/naho/english/pdf/research_tradition.pdf).

The Western medical model of health does not readily incorporate traditional medicine (knowledge, skills and practices). As a nurse, “you must understand and value diversity, and explore traditions and cultural values of the Aboriginal people order to deliver culturally appropriate care”.⁷ Nurses must use their therapeutic relationship skills and be aware of social and cultural barriers when working with First Nations and Inuit people. Only if clients feel safe will they access health care resources.

CULTURE AND HEALTH CARE

“Cultural competence is the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services”⁸ related to the client’s culture. Culturally competent care is important since nurses are obligated to provide ethical care, the Canadian population is culturally diverse and culture is a determinant of health. Each nurse is “responsible for acquiring, maintaining and continually enhancing cultural competencies in relation to the clients they care for. They are responsible for incorporating culture into all phases of nursing process and in all domains of nursing practice”.⁹ Cultural competence can facilitate improved health outcomes.

Cultural safety goes beyond cultural competence by recognizing, understanding and addressing power differentials, as defined by clients (for example, in health care provision). These must be addressed before improved health care access for First Nations and Inuit clients can occur.

To understand a client, it is necessary to have a basic understanding of that person’s values and his or her expectations of self and others. Failing to understand often subtle differences in behavioural norms can easily lead to major misunderstandings, loss of credibility, anger and frustration on both sides.

Values and ideals vary from culture to culture and community to community, so it is impossible to enumerate all the possible differences. Since each community varies in their cultural values and beliefs, nurses must educate themselves about the community they work with and use this knowledge

in their practice.¹⁰ This is done in consultation with “cultural-brokers” (for example, Elders, community health workers, those who are able to operate in both cultures). Topics to learn about include:

- culture, language and lifestyle of the community, including health beliefs, practices and values
- personal culture and lifestyle, including health beliefs and values of the nurse
- how the nurse’s personal culture affects or might affect their practice and/or conflict with the other culture
- history and social circumstances of the community
- historical impacts on health beliefs and status of Aboriginal people and of their community
- health status and beliefs/perceptions of the community (as defined by them)
- what the community considers normal and abnormal behaviour and symptoms
- what the sociocultural causes of disorders are assumed to be
- what the sociocultural responses are to the disorder, including traditional practices and networks and how they bring about resocialization to community norms and goals
- who the healers are (for example, medicine man/woman, midwife, shaman, “doctor” or Elder) and their role in the community
- traditional and Western ways of healing used and their perceptions of them; note that all forms of healing are dynamic and changing, including the scientific approach
- how traditional and Western ways of healing can be integrated
- determinants of health, and socio-cultural and political factors that affect health
- what the community expects of you and your agency

When working with a client of another culture, assume that the individual, family or community has competencies and resources for “self-care”. Involve the members of the community in development of programs and services. Community ownership of services increases the acceptability and appropriateness of the services.

TRAUMA INFORMED CARE¹¹

Traumatic events such as violence, physical or psychological abuse are experiences so profound that they transform the way a survivor constructs a sense of them self and of the world. The repercussions of trauma are felt throughout the person's life and in areas that may seem far from the trauma. The lasting impact puts the survivor at risk of being re-traumatized when dealing with social or health services. It is of prime importance for nurses to be

aware of and sensitive to this reality and to prevent the cycle of damaging effects by considering trauma-informed language and practices.

Trauma Informed: The Trauma Toolkit, developed by Klinik Community Health Centre is a resource for service organizations and providers to deliver services that are trauma-informed. It is available at: <http://www.trauma-informed.ca/>

COMMUNICATION

Communication is the ability to exchange information so that each person has a clear understanding of the other.¹² In communication with someone of another culture, it can be expected that there will be numerous sources of misunderstanding, even if the two parties are speaking the same language. Culture and perhaps even language itself structures one's perception of reality.

It is important to communicate effectively for the following reasons:

- A clear understanding of the client's symptoms, circumstances and perception of the problem is necessary
- Rapport and trust to promote a therapeutic relationship can be established
- Many cognitive and mental disorders are diagnosed by disturbances of thought and perception, which can only be determined verbally and must be differentiated from cultural norms
- Communication must be effective for the client to receive appropriate treatment, including health education

THERAPEUTIC RELATIONSHIPS¹³

"The therapeutic relationship is grounded in an interpersonal process that occurs between the nurse and the client(s)... [It] is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client".¹⁴ It helps build meaningful relationships and promotes effective communication.

A therapeutic relationship has the following key components: respect, empathy, honesty, active listening, trust, genuineness and an ability to respond to client concerns (including cultural ones). It requires that the care provider has many different areas of knowledge (for example, culture, determinants of health), practices reflectively, upholds confidentiality and offers reciprocity. In addition, the care provider needs to be able to self-reflect, be self-aware (for example, of their personal beliefs and values), and have intimate knowledge of professional boundaries. The nurse establishes a therapeutic relationship with the following non-linear process: orientation, working and resolution. Establishing rapport with a client is essential both to conduct an appropriate assessment and also to provide a supportive intervention by decreasing the client's anxiety and uncertainty.¹⁵

HISTORY TAKING¹⁶

When taking a history, a health care provider needs to ensure that they have privacy, refuse interruptions, have the client stay in their street clothes, and have the physical environment set up in a conducive way for client interactions (for example, little noise, sufficient light, no distracting objects).¹⁷ The following considerations should be respected with all clients:

- Assure the client that all information from your interaction with them will be kept strictly confidential (unless suicidal intention, homicidal intention, child abuse or neglect, and/or another high-risk, potentially destructive activity is disclosed)
- Be respectful of all clients, in particular Elders

- The client should be kept as the focus of the interview; attempt to address the problem and understand it from the client’s perspective
- The interviewer must be flexible in order to meet the client’s expectations of where the interview should lead
- Build rapport by starting with their chief concern and less sensitive questions. Move to more sensitive questions
- Do not make assumptions
- Ask open-ended questions as much as possible to ensure that the relationship is supportive, trusting and non-judgmental.¹⁸ Open ended questions encourage clients to tell their own stories about their health status (for example, “Tell me what happens when you walk several blocks?”). They should be used to start the history and for new topics within the history. Closed questions or questions answered by a “yes or no” target specific information and limit rapport building (for example, “Do you have abdominal pain after you eat?”)¹⁹
- More information may be elicited by facilitating continuation of the client’s response. This may be done by using silence, restating, reflecting, empathizing, exploring, clarifying, validating, focusing, confronting, interpreting, explaining and summarizing²⁰
- Ask questions, particularly ones about sexuality, in a gender neutral manner (for example, ‘Have you had sex with anyone?’)²¹

The following are some of the considerations that should routinely be taken into account in communicating and interacting professionally in a cross-cultural situation.

- Words, even in the same language, can have different cultural meanings. Paraphrase and question the client to be sure of mutual understanding
- Judge the level of the client’s vocabulary, considering English as a second language, and respond congruently
- Many First Nations languages have words that do not easily translate²²
- Non-verbal cross-cultural communication behaviours that convey information are vocal cues (for example, pitch, tone, silence), action cues (for example, posture, facial expression, gestures, eye contact), object cues (for example, dress, hairstyle), personal and territorial space, and touch.²³ The meaning of the various behaviours may vary greatly by and even within cultures
- Cultures vary widely in terms of appropriate distances between speakers (personal space), depending upon their relationship and the topic and purpose of the conversation. Standing or approaching too close might be perceived as being “pushy” or aggressive; someone standing too distant may be interpreted as cold, impersonal or anxious. Be alert to your own and the client’s non-verbal cues and to the fact that they can have different meanings in different cultures
- Some emotional subjects (for example, sexuality, drugs, smoking, alcohol) may be considered taboo and should be handled tactfully, sensitively and/or indirectly
- Some questions may be inappropriate or offensive to certain groups of people. This may also depend on the age and gender of the inquirer
- An interpreter is necessary when a different language is spoken, but he or she can also be helpful in providing a “cultural” interpretation, clarifying and explaining for both parties (*see “Use of an Interpreter” below*)
- Communication “style” varies from culture to culture (for example, opening exchanges, getting to the point, directness, bluntness, self-disclosure by the interviewer)
- It may be advisable for the health care provider (interviewer, therapist, nurse) to explain his or her point of view, values and assumptions
- The degree to which each client identifies with his or her culture must be assessed
- Interest and genuineness are traits of the interviewer that can be recognized readily by clients of almost any culture
- First Nations individuals seek social harmony, so they may not fully disclose concerns or feelings and/or they may give you the impression that they agree with you or understand you when they do not.²⁴ Be aware of the communication style of the clients in your communities. Seek confirmation of the person’s understanding when offering information or providing educational content

Some of these considerations require an in-depth knowledge of the culture. Consult experienced healthcare and social service professionals and para-professionals, Elders, cross-cultural workers, interpreters and other members of the community itself. Firsthand experience and knowledge are best, but do not overlook the anthropological and historical literature on your area and its people.

USE OF AN INTERPRETER²⁵

Communication is most effective when the participants share a common language and culture, so that verbal and nonverbal messages are congruent and cultural values and beliefs are clear. To enhance communication when a client's culture or language is not the same as the care provider's, an interpreter service or community interpreter should be used. The following suggestions for working with an interpreter during nurse-client interactions will help facilitate effective communication.

- Ensure that the interpreter and client speak the same dialect of language and the interpreter is bilingual and knowledgeable of medical terminology
- It is best to avoid relatives, friends, community members, or those of the opposite sex as interpreters, if possible, to maintain confidentiality and so the interpreter is more of a neutral person in the information exchange (for example, not stating information that the client has not provided)
- Ask the interpreter about correct protocol (for example, dress, handshakes, conversation etiquette, type of questions that may be asked, “personal space,” use of first names, presence of the interpreter, health practices, and the cultural appropriateness of management techniques)
- The interpreter is a professional and should be acknowledged as such
- Be respectful and polite, as a professional. Maintain eye contact if it does not appear to make the interpreter uncomfortable. Use the client and interpreter's name. Speak slowly in a normal tone of voice. Volume does not compensate for difficulty with vocabulary or syntax
- Discuss confidentiality. Be sure that you understand the interpreter's relationship to the client and that it does not pose a problem
- Ask the interpreter to translate line by line for most of the interview. This means that both the care provider and the client should only speak one to two sentences before the interpreter translates. When teaching simple concepts that are familiar to the interpreter, give the interpreter the authority to summarize and translate
- Avoid ambiguous, conditional, abstract, metaphorical, medical jargon, and/or indefinite language
- Ask the interpreter for feedback at each step to be sure that communication takes place

- Ask for brief summaries from the client to ensure that all three parties have a mutual understanding of what has been discussed
- Explain to the interpreter that impressions of nonverbal communication, including feelings and emotions should be described, in addition to the client's verbalizations
- Be alert for incongruence between verbal and nonverbal communication, and ask the interpreter to explore any suspected problems
- Describe what will happen during diagnostic tests, so the client understands what to expect
- Have the interpreter choose the appropriate words for possibly sensitive or taboo subjects, such as sex, and indicate to him or her that you are not expecting a literal translation. Ask for a translation of what was said to be sure that the translator's interpretation was close enough to the intended meaning

COMMUNICATION BETWEEN HEALTH CARE PROVIDERS^{26,27,28}

To provide safe and quality health care effective and efficient communication between health care providers is essential. A structured mode of communication, known as SBAR (Situation, Background, Assessment, Recommendation) has been shown to improve communication between care providers, ensuring that important information is not missed, the message is clear, it is put into a relevant context and it is presented succinctly. Care providers need to be assertive and use key words so that their message is clear. SBAR helps do this by providing structure to situational briefings.

Using SBAR, information is organized into 4 groups:

- Situation – what is going on (for example, client and care provider names, location, problem (what, when, how severe)) briefly in 5–10 seconds
- Background – data to support conclusion (for example, relevant information on past medical history, context, vital signs, assessment data, medications, lab results)
- Assessment – conclusion (for example, from your perspective how severe is the problem and what is the diagnosis that is suspected)
- Recommendation – the plan (for example, what you think should be done and/or what you want)

Two different tools for the SBAR communication process (worksheet and report template) are available at: <http://www.rgpc.ca/best/BPC%20-%20Hydration/SBARWorksheetFinal.pdf> and http://www.paediatricchairs.ca/safety_curriculum/domain3_docs/SBAR-Tool.pdf.

In order to utilize this method of communication effectively, ensure the assessment includes the most relevant details to be shared, having the client chart and current medication list close at hand and recent diagnostic test results readily available. After the consultation, the reason for consultation and, new orders should be documented in the client's chart. Consider underlined in red any significant new entries to facilitate internal provider communication.

HEALTH ASSESSMENT^{29,30}

A health assessment is when one collects information about a client's health status.

Different types of health assessments may include:

- complete (for example, physical for preventative care) where a full history and physical examination occurs, including screening for disease
- episodic (for example, for a rash) where the chief concern is limited in time
- follow-up (for example, for a client with diabetes) where a health concern is monitored regularly and at appropriate intervals
- emergency (for example, for a myocardial infarction) where data is collected quickly, often while providing lifesaving measures

Each situation will require a different amount of information to be gathered on the client.

AGE DEFINITIONS³¹

As per Health Canada's Community Health Nursing Data Set, the age definitions found in the following table will be used throughout the clinical practice guidelines, if the age group is not clearly stated.

Table 1 – Client Group and Associated Age

Group	Ages
Infant and child	0 to 5 years
Newborn	0 to 28 days
Infant	1 to 18 months
Preschool child	4 to 5 years
School aged child	6 to 10 years
Adolescent	11 to 19 years

HISTORY

A health history is the most important part of a health assessment as it is key to reaching an accurate diagnosis. A thorough history should include the following components:

- Identifying information, including age, gender, race, marital status, occupation
- Source of information and reliability (if applicable)
- Reason for visit/chief complaint(s)
- History of present illness/presenting concern – detailed account of symptoms and related events in chronological order and in client's own words (where possible)
- For each cardinal and associated symptom (including those discovered under review of systems) describe:
 - Location (anatomical) and radiation (if applicable)
 - Onset
 - Progression
 - Quality
 - Quantity or severity
 - Timing (duration, frequency)
 - Setting (when it happens and when it started)
 - Aggravating and alleviating factors
 - Associated symptoms
 - Treatments tried
 - Previous occurrences
 - Effect on client's life

- Current health information
 - Past medical history (include general health, childhood and adult illnesses, current and past medical conditions, surgeries, hospitalizations, blood transfusions, accidents and injuries, obstetric history); for children also include prenatal, birth, neonatal, and growth and development history
 - Allergies (include the type of reaction)
 - Current medications (include dosage and frequency for prescriptions, home remedies, traditional medicines, vitamins, minerals)
 - Immunizations and screening tests (for example, mammogram, tuberculin skin test)
 - Health maintenance activities (for example, hearing, vision, dental, Mantoux, pap smear, mammogram, cholesterol testing), dates and results
 - Family history (include disease [in particular, diabetes, mental health, hypertension, heart disease, arthritis, tuberculosis, epilepsy, headaches, addictions, cancer, birth defects, immunocompromised], age, health and/or age and cause of death for parents, siblings, spouse and children); may be done in a genogram
- Personal and Social History
 - Use of tobacco, alcohol, drugs, caffeine (for children; personal and household/parental use)
 - Exercise/activity
 - Diet, 24 hour recall (in pediatric clients include amount and types of foods, eating habits)
 - Sleep/rest
 - Travel
 - Self-esteem
 - Interpersonal relationships and resources (for example, partner, family, friends, community)
 - Occupational history and exposure to toxins; school or daycare for children
 - Environment (for example, home (current and past), transportation)
 - Education
 - Home situation (for example, who lives there, provides child care, dynamics), daily life
 - Leisure activities
 - Important past experiences (for example, school, work, marriage)
 - Spiritual resources
- Stressors (for example, finances) and coping skills; for pediatric clients include parental readiness, knowledge, attitudes, expectations and response to problems
- Sexual health and practices (for example, number and gender(s) of partners)
- Subject to violence or abuse (financial, emotional, verbal, physical, neglect)
- Activities of daily living and instrumental activities of daily living
- Hobbies and interests
- Behaviour (including risk taking)
- Safety, in particular for children (for example, where sleeps, heating source, running water)
- Perception of personal health state
- Review of Systems (extensive questions for the body systems that relate to the presenting chief complaint and brief assessment of all other systems; for children ask about present symptoms not past history)
 - General – (for example, weight change, chills, sweats, weakness, fatigue, fever, appetite change, sleep patterns)
 - Integumentary
 - Head, Hair, Ears, Eyes, Nose and Sinuses, Mouth, Throat
 - Neck
 - Breasts and Axilla
 - Respiratory
 - Cardiac
 - Gastrointestinal
 - Genitourinary
 - Peripheral Vascular
 - Musculoskeletal
 - Neurologic
 - Hematologic
 - Endocrine
 - Mental Health

The detailed and specific components of a particular body system's (for example, musculoskeletal) history are detailed in the specific *First Nations Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care* chapter that corresponds to the system. Refer to the relevant chapter.

PHYSICAL ASSESSMENT

A complete physical assessment should include the following components:

- General appearance of client (for example, physical appearance, body structure, mobility, behaviour, personal hygiene, speech, mood and affect, appropriateness of dress for season)
- Vital signs (for example, temperature, pulse, respirations, blood pressure, oxygen saturations)
- Measurements (for example, weight, height/length, waist circumference, head circumference in children; plasma glucose or haemoglobin levels); graph for a percentile (paediatrics) or body mass index
- Pain assessment using an objective form of measurement (for example, visual analog scale)
- Mental health assessment
- Growth and developmental screening (for pediatric clients)
- Fetal assessment (for pregnant females)

- All body systems assessed through an inspection, palpation, percussion, and auscultation approach
 - Integumentary
 - Head, Hair, Ears, Eyes, Nose and sinuses, Mouth, Throat
 - Neck
 - Breasts and axilla
 - Respiratory
 - Cardiac
 - Gastrointestinal
 - Genitourinary
 - Peripheral Vascular
 - Musculoskeletal
 - Neurologic

The detailed and specific components of a particular body system's (for example, musculoskeletal) physical assessment are detailed in the specific *First Nations Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care* chapter that corresponds to the system. Refer to the relevant chapter.

CRITICAL THINKING

“Critical thinking is the means by which we learn to assess and modify, if indicated, before acting... A critical thinker is simultaneously problem-solving while self-improving his or her thinking ability”.³² Critical thinking is a tool of inquiry that involves the use of skills, knowledge (both deep and broad) and attitudes (including scepticism). For nurses it involves taking a lot of information and data, assimilating it and then adapting it to clarify the problem (simple or complex) and the solution. This occurs while being open to questioning, suspending judgement, and reflecting on the reasoning process used. The critical thinking process is essential for sound clinical judgment, formulating diagnoses and to effectively and safely provide personalized client care.³³

Critical thinkers use many skills in a multifaceted thinking process. These skills include:³⁴

- Identifying assumptions
- Assessing using an organized and comprehensive approach
- Validating data (for example, accuracy, reliability)
- Identifying normal from abnormal assessment data
- Making inferences (for example, valid conclusions)
- Grouping related data (clustering)

- Identifying relevant versus irrelevant data
- Recognizing inconsistencies in data
- Identifying patterns in data
- Recognizing data gaps
- Promoting health by finding risk factors
- Identifying actual and potential diagnoses
- Setting priorities when there is more than one diagnosis (for example, acuity of each concern)
- Identifying specific interventions to reach the client's goals of treatment
- Evaluating (based on goals of treatment) and altering thinking based on a client's progress
- Making, implementing, recording, communicating, evaluating and updating a comprehensive management plan

ESTABLISHING A DIAGNOSIS

Establishing a diagnosis depends on a care provider's knowledge and experience, the prevalence of the disease, diagnostic tests used, and the clinical presentation. A diagnosis may be established by induction, deduction (based on probability) or pattern recognition (for common diagnoses in one's field of expertise).³⁵

The scientific method can be used in diagnostic reasoning by:^{36,37}

- Paying attention to clues (for example, sign, symptoms, laboratory data) available early on and identifying the most important ones
- Hypothesizing diagnoses (consider all potential diagnoses that are applicable to the client)
- Gathering relevant data during your client assessment (for example, in depth history, physical assessment, and diagnostic tests) for the hypothesized diagnoses. Data are clustered to be associated with specific diagnoses or anatomical locations
- Evaluating each hypothesized diagnosis with the new data (for example, rule in [presence of data that is strongly associated with the diagnosis] or rule out [no data findings exist that are frequently seen with the diagnosis] these potential diagnoses) to arrive at a final diagnosis or list of differential diagnoses. Test each diagnosis for coherence (does the diagnosis makes sense given the client’s risk factors and complications), adequacy (does the diagnosis utilize all the data), parsimony (is the diagnosis the simplest explanation for the data), and ability to eliminate another diagnosis.³⁸

To determine a correct diagnosis two things must occur: patient data must be collected and the data must be analyzed. If the data is inadequate (for example, due to a relevant part of the exam not being done) or in error (for example, due to the care provider not distinguishing appropriately a normal or abnormal finding), the diagnosis may not be accurate.³⁹ Data should be grouped together if they are causal or associated (for example, pain, tachycardia, anxiety). These data clusters may be evident at the first visit or may develop over time (for example, when initial treatment is not effective).⁴⁰ In addition, any data that needs to be confirmed should be verified (for example, ask a colleague to listen, ensure blood pressure was not influenced by anxiety).⁴¹ This ensures that the data being used is accurate. In addition, the care provider must analyze the data they collect with knowledge of basic science and clinical medicine in order to associate the data abnormalities with various disease processes.⁴²

MANAGEMENT⁴³

After a diagnosis is made, one wants to choose the management plan that is most likely to result in the outcomes that the client desires (for example, using a risk benefit analysis from the client’s perspective). Some clients are interested in having symptoms relieved whereas others want reassurance that a symptom or sign is not serious. Goals of treatment may be negotiated based on the client’s needs and wishes and the need to ensure that the client does not have a serious condition.

NON-PHARMACOLOGICAL INTERVENTIONS

These interventions should encompass non-pharmacological treatments (for example, ice, rest), health education including when and/or why to follow-up, health promotion and disease prevention interventions, and anticipatory guidance for the client’s specific health condition.

PHARMACOLOGICAL INTERVENTION CONSIDERATIONS

A best possible medication history should be taken, for instance using an interview guide, medical record and medication profile.

To prescribe, dispense and/or administer a medication safely:

- For calculation of pediatric weight-based dosages using mg/kg/day formula, ensure the child’s weight is correct and calculations are double checked. Ensure that calculated weight-based dose does not exceed the recommended adult dose

- Best practice when dispensing, in particular for high alert medications such as narcotics, is to have another health care provider perform an independent double check of the dosage to decrease the risk of error and to promote client safety. The drug contents and the information on the medication bottle being dispensed to the client should also be double checked by another provider to ensure it is the right drug in the right container with the right directions (as per prescription)
- Repeat any prescription obtained verbally (for example, by phone) to the prescriber to confirm its accuracy

The information on the label of the medication bottle dispensed to the client should include the following elements, preferably typed or computer generated:

- client's name
- generic medication name and manufacturer's name
- strength
- client's directions for use
- quantity dispensed
- date dispensed
- name of the prescriber
- name, address (if applicable) and phone number of the health facility
- prescription number (when applicable)
- auxiliary labels when necessary (for example, Shake well, Take with food)

CLINICAL RESOURCES

MULTIDISCIPLINARY TEAMS

The health care team is made up of a broad base of care providers that may provide on-site or off-site services. They include the disciplines of social work, speech language pathology, psychology, psychiatry, medicine (including all specialities), optometry, naturopathy, massage therapy, chiropractic, physical therapy, occupational therapy, nursing, midwifery, unregulated health professionals, dietetics, dentistry, audiology, and dental hygiene. On-site care providers such as child and youth workers, community health representatives (CHR), National Native Drug Abuse Program (NNADAP) workers, and community mental health workers.⁴⁴ It is essential that all of these care providers involved in a client's care, work together to provide the best health care for each client. The nursing personnel being primary providers play an important role in coordinating the on-site and off-site team interventions.

Competencies for multidisciplinary team members providing health services and supports are:^{45,46}

- communication
- patient/client/family/community-centred care
- role clarification
- team functioning
- collaborative leadership
- conflict resolution

NURSING CLINICAL RESOURCES

- Registered users of the NurseOne Portal (available at: <http://www.nurseone.ca>) under the Home tab, will find information on First Nations and Inuit Nursing and Rural and Remote Nursing; while the Library tab has a number of ebook and ejournal links (for example, eTherapeutics, eCPS)
- Sources listed at end of each chapter of the *First Nations Inuit Health Branch Practice Guidelines for Nurses in Primary Care*

DOCUMENTATION⁴⁷

Documentation is a method of communication that includes manual (paper) and electronic (computer) charting.

OBJECTIVES OF DOCUMENTATION

- Communicate among health professionals, and ensure continuity of care
- Provide access to and easy retrieval of health information
- Provide standardization of health records to ensure a complete, accurate, comprehensive, timely, and consistent method of recording client information
- Reflect the care and/or service provided to the patient
- Keep records of professional practice in accordance with accepted standards of practice of the nursing profession
- Demonstrate the accountability and responsibility of nurses in professional practice
- Provide a source of information to evaluate professional practice during quality assessment processes, such as chart audits

PURPOSE

Documentation in a client record is essential in order to communicate:

- Assessment findings
- Differential diagnoses
- Diagnostic testing completed
- Treatment and follow-up plans
- When a patient did not show up for an appointment
- When and what health information was transmitted, including the client's informed consent to transmit personal information
- A client's death (for example, include date, cause, time, who pronounced death, if known)

It is particularly important for liability purposes to thoroughly document all of the above information.

ESSENTIAL COMPONENTS AND FEATURES^{48,49}

- The minimum client identifying data includes the client's name including family names, current address, birth date with month written out and year, age, sex, unique chart identifier/ number, Department of Indian Affairs of Northern Development (DIAND) number, provincial health number, names and phone numbers of next of kin or guardian, and mother's maiden name. Regional protocols may define the information to be found on every page of the client record. As a safety measure, the client's allergy status should be noted on every page
- Note that in 2011, the DIAND was renamed Aboriginal Affairs and Northern Development Canada [AANDC])
- Date and time for all charting entries, including time of care provision and time of documentation (if different). Clearly mark late entries as such
- No empty lines – a line should be drawn through any space not used
- Who is giving the history if other than the client
- The reason for the call or visit (as part of subjective data), advice or information given, follow-up required, consultations with other health care providers
- All relevant client-focused care, including direct care, telephone advice, and consultations
- Errors corrected in an open and honest manner with the original information remaining visible and retrievable. This is done with a single line through the error with the word 'error' and the reason for the error written above it along with your signature and designation
- Corrections made as soon as possible after they are discovered and by the person who made the original entry
- That the client has given informed consent to treatment and/or transmission of personal health information

- A face sheet in the client record with the client’s current health (including, *but not limited to*, medical diagnoses, all medications taken, immunizations and dates given, allergies and adverse reactions or intolerances, review of systems, ongoing health problems/conditions/concerns), past medical history, family medical history, personal/social history (including, but not limited to First Nations status, country of birth/citizenship, place of birth, employer, preferred language, other languages spoken, parents/guardians/agency, relationship status, partner’s name), health literacy, primary health care provider, current, other and previous addresses, registered First Nations community of residence, whether lives within First Nations community of residence, other medical payment sources, emergency contact, and next of kin/guardian listed
- Only regionally approved abbreviations and data collection forms should be used
- Observations that are factual, unbiased, quantitative, and timely (for example, completed only during or after giving care and as soon as possible)
- Concise, accurate, specific and objective entries
- Chronological entries
- Legible (including errors and corrections) and written in permanent non-erasable black or blue ink (including medications). Entries should never be deleted, but they may include clearly identifiable changes and corrections. Entries should not be highlighted
- According to SOAP charting format
- Pharmacologic intervention documentation needs to contain the following elements: the name of the medication, the strength of the medication (for example, 10mg/tablet), the dosage the client is to take (for example, 1 tablet), the frequency (for example, bid), the route, the duration of treatment, how much medication was dispensed to the client, and the name of the prescriber if it is other than the person who is documenting
- Completed by the person who was directly involved in the event except when an individual observing care is acting as a designated recorder for a team (for example, in a cardiac arrest). In this case who provided what care and who did the documentation must be clearly defined. Never delete, alter or modify another person’s documentation
- Signed by the person making the entry, including a legible initial and full last name, and indicating that person’s professional designation (for example, RN)
- Only accessed when there is a professional need

SOAP DOCUMENTATION

Each part of the SOAP (Subjective, Objective, Assessment, Plan) note should include the relevant information.

Subjective

- reason for visit or call, chief complaint/concern
- history of presenting illness/condition/concern
- review of current health information (on face sheet)
- review of systems (any pertinent information from the remaining body systems that relate to the presenting chief complaint)
- past medical history
- family history
- personal and social history (for example, smoker)

Objective

- objective findings (physical examination and during interview) by system with each system documented in an IPPA format (I-inspection, P-palpation, P-percussion, A-auscultation)

Assessment

- assessment (your differential and definitive diagnoses based on the information above)

Plan

- management plan, including diagnostic tests, non-pharmacological and pharmacological interventions, health teaching, follow-up and evaluation (for example, when to reassess the condition, referrals made)

Refer to Appendix A and B for documentation examples of a pediatric episodic assessment and an adult comprehensive health assessment.

CONSENT TO MEDICAL TREATMENT⁵⁰

Unless care is provided on an emergency and life threatening basis, medical treatment should be provided under informed consent.

Informed consent requires the health care provider to disclose adequate information about the proposed treatment in order for the client to make a decision for or against treatment. The information should include:

- the reasons for treatment
- seriousness and the risks of the specific treatment
- the risks of refusing treatment, possible alternative treatments
- answers to any questions the client may have⁵¹

For the consent to treatment to be valid, two requirements must be met: the client must be knowledgeable about the treatment and be free to decide to consent.

In establishing validity, the health care provider must be assured that:

- The client is legally competent and has the mental capacity to consent to treatment
- The client is given proper disclosure of information from the health care provider and the opportunity to ask questions and receive suitable and understandable answers
- The client comprehends the information given by the health care provider
- The consent is specific to the procedure or treatment
- The consent is given voluntarily and free from coercion, undue influence and misrepresentation of material information

REFUSAL OR WITHDRAWAL OF CONSENT

At any time, a client has the right to refuse treatment, withdraw his/her consent to treatment and refuse medical evacuation.

Regional protocols provide guidance when treatment is refused or consent is withdrawn. If the refusal of treatment is for a child, consider if the circumstances could constitute maltreatment and should be reported to a child welfare agency. *Refer to pediatric Chapter 5, “Child Maltreatment”* for information on reporting to child welfare agencies. Refusal of treatment or withdrawal of consent should be further documented in the client’s chart.

AGE OF CONSENT TO MEDICAL TREATMENT

In order to consent to medical treatment, the client must be assessed by a health care provider as having the ability to understand the information provided and the competency to provide a valid consent. The client must receive sufficient relevant information to understand the prognosis, diagnosis, be capable of discerning the nature, purpose, risks and benefits of a treatment, and receive suitable and understandable answers to questions asked.

Some provinces/territories have legislated ages of consent at which minors may be considered competent to consent to medical treatment regardless of the legal age of majority provided for in the laws of a province or territory or that the minor is of an age where child protection laws would still apply. This is referred to as the minor majority rule that would allow a health care provider to act on the direction of a minor if he or she believes the minor is capable of making mature decisions that are in his or her best interests.

If a minor does not have the legal and/or mental capacity to consent to treatment, a parent or legal guardian will have to provide consent on behalf of the minor. If the parent or legal guardian is not available to give consent, the nurse should document the situation, including the relationship of the informal caregiver to the child, and include why the informal caregiver is acting in the best interest of the child and can provide consent on behalf of the child. Documentation should provide details about the situation that satisfies the provider the individual accompanying the child is the individual who has taken responsibility for the child’s health care and there is no parent, legal guardian or other substitute decision-maker available to provide consent on behalf of the child.

For adults who are determined not to have the mental capacity to consent to treatment, the health care provider must identify and obtain consent from an appropriate substitute decision maker who is legally competent to act on behalf of that individual. Provincial or territorial legislation usually provides for consent to health care treatment by a substitute decision maker on behalf of a patient/client. Any consent or substitute consent process should be documented by the health care provider.

WHEN CONSENT IS IMPOSSIBLE OR IMPRACTICAL TO OBTAIN

In an emergency situation when the client's life or health is immediately threatened, the client has not refused treatment, and it is impossible or impractical to obtain their consent or that of their closest relative, the nurse should proceed with the most appropriate treatment and document the care given in the client's chart.⁵²

Failure to obtain informed consent from clients prior to treatment may be subject to disciplinary action up to and including summary dismissal for cause by the employer, and disciplinary action from their nursing regulatory body.

PRIVACY AND ACCESS ISSUES – RECORDS AND CONFIDENTIALITY⁵³

GENERAL

Health records (both manual and electronic), including personal and personal health information about medical and psychosocial interventions require the utmost care to ensure and maintain confidentiality consistent with the federal *Privacy Act* and policies including the Treasury Board Policy on Government Security, and Privacy laws. Records may contain very personal and sensitive information. Nurses must protect client confidentiality as part of their legislative and professional obligations.

Health records containing personal information, including medical and psychosocial information, should not be shared with family (including spouse or children), friends or other health care professionals unless the client has provided informed consent to the sharing of their health records. Consent in writing is preferable as it provides confirmation and the best evidence of consent.

Breaching the confidentiality of health records can be particularly damaging insofar as:

- Clients presenting with certain health problems are more vulnerable to public embarrassment and to the prejudices and biases of others, including employers
- Mental health problems and some other health concerns have personal and social components, where disclosure may have an impact on others besides the client involved
- Legal issues may be involved, and the client may be compromised

- Disclosure would undermine public confidence in the health service, the personnel and the organization
- Some clients, because of personality disorders or mental illness, are more likely to try to gain access to information or to misuse anything learned

Doctor-client or nurse-client “privileged communication” does not exist in Canada. All health personnel are required by law to disclose information under certain circumstances (for example, give evidence if subpoenaed for that purpose).

There is no clear statement in common law with regard to breach of confidentiality, which means that each case would be contested on the basis of principles other than common law precedent.

DISCLOSURE OF PERSONAL INFORMATION

Personal information refers to information recorded in any form that can identify an individual as defined in the federal *Privacy Act*, and includes information for which there is a serious possibility that the individual can be identified.

Confidentiality of a client's personal information including health records, and the purpose and nature of the content of any medical intervention (even the fact that the client sought medical attention or has been seen) is protected under the federal *Privacy Act*, the *Canadian Charter of Rights and Freedoms* and in cases where an access to information request is made, the federal *Access to Information Act*. Health Canada employees (including personnel providing care under contract with the department) must comply with the aforementioned federal legislation and policies obligations.

Different circumstances may require the disclosure of a client's personal information. Some are described below. If at anytime a circumstance that may require the disclosure of a client's personal information arises and it is unclear whether the information should be disclosed, contact the ATIP Coordinator at 613-965-9154 to receive guidance and/or permission to disclose personal information. The federal *Privacy Act* and a 2007 Delegation Order of the Minister of Health delegates to the ATIP Coordinator the responsibility for disclosure of personal information within federal legal and policy requirements.⁵⁴

All cases of disclosures must ensure that the personal information to be disclosed is accurate, the least amount of personal information possible is disclosed, and third party information that should remain confidential is withheld.

1. DISCLOSURE OF PERSONAL INFORMATION WITH CONSENT OF THE CLIENT

A client's personal information may be disclosed if the client individually consents to the disclosure. Consent is documented in the client's health record.

If the client consents to transmission of health records to another care provider or agency, it is important to ensure that the original record is kept and that the transmission safeguards the client's confidentiality (for example, fax cover sheet states "Confidential").

2. DISCLOSURE OF PERSONAL INFORMATION IN A "CIRCLE OF CARE"⁵⁵

"Circle of care" (defined in the FNIHB Privacy Standard Operating Procedures [revised 2011-01-27]) refers to health care providers who are directly involved in the care and treatment of a patient. Professionals within the circle of care may include the primary care nurse, the primary care physician, a specialist, a midwife, a medical laboratory or a pharmacist. Regardless of the health care discipline, a health care provider to whom the information is disclosed within the circle of care, is directly involved in the care, treatment and/or follow-up of the individual and the disclosure is documented in the client's health record.

Information may be disclosed within the circle of care if at least one of the following conditions is met:

- Specific or implied consent has been granted by the patient
- Disclosure of the information is necessary for the care and treatment of this patient
- There is a critical health emergency or
- The ATIP Coordinator has approved the disclosure

3. DISCLOSURE FOR AN EMERGENCY SITUATION

In an emergency situation (an immediate urgent and critical situation of a temporary nature, regardless of its cause, which may seriously endanger or threaten the lives, health or safety of individuals), personal information may be disclosed if:

- A reasonable person would agree that an immediate disclosure was necessary, and
- The disclosure averts or minimizes an imminent danger to the health or safety of any person, and
- The disclosure needs to occur within a timeframe where it would be impossible or detrimental to the health of the individual to receive permission from Health Canada's Access to Information and Privacy (ATIP) Coordinator

After the emergency disclosure and once the client is stabilized, Health Canada's ATIP office (613-965-9154) must be informed immediately.⁵⁶

4. DISCLOSURE TO A THIRD PARTY⁵⁷

Third party requests come from anyone other than:

- The client or patient to whom the information relates
- Health care professionals directly involved in the client's care and treatment
- A Health Canada employee in possession of the client's personal information

Common examples of third parties include law enforcement officials, private insurers, financial institutions, employers or colleagues without a formal need to know about a client's personal information and personal health information.

Information may be disclosed to third parties by a Health Canada employee under one of three situations:

- The individual to whom the information relates has granted his or her consent
- There is a critical health emergency
- Health Canada’s ATIP Coordinator has approved the request

If personal information is requested from a third party, one of the above situations (client consent, critical health emergency or ATIP approval) must be met before the information may be disclosed.⁵⁸

5. DISCLOSURE ON A PROACTIVE BASIS⁵⁹

Proactive disclosure refers to situations where personal information is released by a Health Canada employee without having been asked to do so by a third party.

Proactive disclosures may be made by a Health Canada employee under one of three conditions:

- The individual to whom the information relates granted his or her consent
- There is a critical health emergency
- Health Canada’s ATIP Coordinator has approved the disclosure

Common examples of proactive disclosures are when Health Canada employees may be required to report professional misconduct to a licensing body that may involve disclosing a client’s personal information, or act in accordance with provincial child protection legislation or with the requirements of provincial public health authorities by reporting an incident. Note that Health Canada employees and contract personnel are required to comply with the federal *Privacy Act* and, the *Charter of Rights and Freedoms* in situations where provincial legislation or professional regulations may conflict with federal legislation and policy requirements. Also note that Health Canada employees and contract personnel are bound to comply with the federal *Access to Information Act* whenever an access to information request is made. One of the above circumstances, namely client consent, critical health emergency or ATIP approval, must be met before the personal information may be disclosed.⁶⁰

A written consent form to disclose health records on a proactive basis includes but is not limited to, the name and address of the person the records will be released to, the name and signature of the client (or parent or legal guardian), the date, a witness’ signature, and what part of the chart can be released. In addition, the consent form should inform the client of the purpose(s) of the disclosure, their right to limit the information disclosed and that they are not precluded from receiving health care if they do not provide their consent.

Information requested by child welfare authorities having legal guardianship of a child may be granted without consent of a natural parent. Written documentation verifying that a child is a ward of the state should be requested from and provided by the child welfare authority and placed in the child’s records.

CONFIDENTIALITY

Maintenance of confidentiality in small and rural communities, maintaining confidentiality can be particularly challenging for health care providers. Many health concerns and/or potential treatments are sensitive subjects which may discourage some clients from seeking health care or cause them to avoid or delay necessary treatment because of concerns about their privacy. It is paramount that sound confidentiality measures be in place and adhered to by all health providers. Many health concerns (for example, depression) and/or potential treatments (for example, emergency contraception) are sensitive subjects and fear of a confidentiality breach may cause individuals to avoid or delay necessary treatment. It is therefore, paramount that effective measures to maintain client confidentiality are in place and adhered to by all health care providers.^{61,62}

It is important to inform clients about the limits of confidentiality and when it may not be maintained (for example, among others, where a client discloses suicidal or homicidal intention, child abuse or neglect, or other high-risk, potentially destructive activity, or where disclosure of personal information is the result of a subpoena, court order or warrant).

As a Health Canada employee and/or contractor, and regulated provider, the deliberate or unwarranted violation of patient confidentiality is subject to disciplinary action up to and including summary dismissal for cause.

APPENDIX A – SAMPLE DOCUMENTATION FOR A PEDIATRIC EPISODIC ASSESSMENT⁶³

Demographic Data: James Bluebird June 12, 2008, Male, 301 Anyband, 15 East St. Anyband Canada
Next of kin: Jack and Jill Bluebird 123 456-7890; Peacock
September 23, 2010 1045

S	CC: Mother, Jill Bluebird, states client “was crying and fussy all night and feels hot”
	HPI: Mother, Jill Bluebird, states client “Tugging on left ear for past day” (intermittently for 18 hours); was “a little fussy” yesterday; went to sleep with pacifier last night, but woke up numerous times crying which is unusual for him (slept as usual prior to last night); settled somewhat when picked up and held; drinking 6x 4 oz/day (16oz of milk, 8oz water) – slightly less than usual; little solid food for past day; felt hot to touch all night; mom gave 150mg Tylenol once at 0100 today and client settled for 4 hours; no other medications have been given; no loss of hearing or ear discharge noted by mother
	PMH: <i>Medications:</i> none, except Tylenol when client “feels hot”; no antibiotic use since 2008 <i>Immunizations:</i> last DTaP-IPV, Hib, MMR December 2009; all routine childhood immunizations completed for age <i>Allergies:</i> none known <i>Medical illnesses:</i> acute otitis media at 6 months of age (2008), treated with antibiotics; no other medical illnesses <i>Last physical exam:</i> 18 month well baby assessment done December 2009; regular well baby care completed on time <i>Hospitalizations/Surgeries/Accidents/Injuries:</i> none <i>Prenatal/Labour and Delivery history:</i> Mrs. Bluebird received regular prenatal care. James was born at 39 weeks’ gestation, labour and delivery were uncomplicated. James weighed 3200g at birth and was discharged 2 days after birth
	<i>Diet:</i> Bottle fed until 13 months; solids introduced at 5 months; now drinks from sippy cup Family History (a genogram also works well and could be included on the face sheet): <i>Parents:</i> 30-year-old father (type 1 diabetes); 27-year-old mother (alive and well) <i>Paternal grandparents:</i> 55, M: alive and well; 50, F: type 1 diabetes <i>Maternal grandparents:</i> 52, M: type 2 diabetes; 49, F: hypertension <i>Siblings:</i> 5 year old male alive and well; 4 year old female 5 episodes acute otitis media in lifetime
	Personal and Social History: Mother states has good relationship with parents and 2 older siblings; lives in a house with parents, sibling and paternal grandparents; shares a bedroom with 2 older siblings; Mrs. Bluebird takes care of children in their home, although 5 year old attends school half days. Mr. Bluebird is a construction worker in the community. Both parents smoke 1 pack/day. Nobody else at home is sick.
	REVIEW OF SYSTEMS
	General: male child with no weight changes, no lethargy or decreased activity
	Integumentary: no rashes or lesions noted by mother
	Head/Neck: <i>Eyes:</i> no discharge or concern about vision <i>Nose:</i> some clear discharge for past 2 days <i>Mouth & throat:</i> no voice changes, no hoarseness
	Respiratory: no shortness of breath, occasional non-productive cough for past 3 days
	Gastrointestinal: no abdominal pain or tenderness; no nausea, vomiting or diarrhea; no constipation; no weight loss
	Genitourinary: no frequency, urinary retention or dysuria, not toilet trained yet
	Musculoskeletal: no heat, redness, swelling, or stiffness in any joints
	Neurological: no history of seizures, no speech or behavioural changes

O	<p>General: alert, active, 27 month old male; crying at times and fussy; developmentally appropriate for age</p> <p>Vital Signs: weight: 16.0 kg (97th percentile); Temp: 38.4 (axillary); pulse: 125; Resp: 30</p> <p>Integumentary: pink in colour, warm to touch, dry, no rashes or lesions</p> <p>Head/Neck: <i>Head:</i> skull: anterior and posterior fontanelles closed <i>Eyes:</i> lids & lashes: no redness, edema or discharge <ul style="list-style-type: none"> • sclera white, conjunctiva clear, red reflex present bilaterally <i>Ears:</i> pinna: bilaterally no lesions or tenderness over tragus or mastoid <ul style="list-style-type: none"> • canal: bilaterally no discharge, swelling, redness, tenderness, wax, or foreign body • tympanic membrane: right opaque, light reflex seen, bony landmarks seen, no bulging, no scarring, no fluid, no perforations, mobile on pneumatic otoscopy; left dull red and bulging, no light reflex or bony landmarks seen, no mobility on pneumatic otoscopy • hearing: follows verbal directions of mother <i>Nose:</i> moderate amount of clear discharge bilaterally; no inflammation; Nares patent; no edema; no deviated septum; no polyps <i>Sinuses:</i> no tenderness of maxillary or frontal sinuses <i>Mouth/Throat:</i> oral mucosa moist and pink; no lesions or exudate; tonsils 1+ <i>Neck:</i> supple, no enlarged or tender lymph nodes</p> <p>Respiratory: <i>I:</i> symmetrical breathing effort; no cyanosis; no accessory muscle use <i>P:</i> no areas of tenderness; equal chest expansion <i>P:</i> resonance throughout <i>A:</i> breath sounds clear and equal bilaterally to bases with no adventitious sounds, regular rhythm, unlaboured, no cough heard during examination</p> <p>Cardiovascular: <i>I:</i> no pulsations or heaves noted <i>P:</i> PMI at 5th ICS, MCL <i>A:</i> S₁, S₂ present, no murmurs; regular rhythm; all peripheral pulses equal bilaterally</p> <p>Abdomen: <i>I:</i> rounded, no masses, symmetrical <i>P:</i> tympanic throughout <i>P:</i> soft; no tenderness; no masses; no hernias; liver edge smooth; spleen not palpable; no CVA tenderness <i>A:</i> bowel sounds present in all 4 quadrants, no bruits</p> <p>Genitalia: external genitalia and buttocks: no masses, redness, tenderness or rashes</p> <p>Risk factors: exposed to second-hand smoke at home (both parents smoke 1 pack/day), not breastfed, older sister has history of acute otitis media, male, Aboriginal, fall month, uses pacifier</p>
A	<p>Diagnosis: acute otitis media left ear</p>
P	<ol style="list-style-type: none"> 1) Watchful waiting for 48 hours before antibiotic therapy is initiated since client is >2 years of age, is mildly unwell, and does not have risk factors for antibiotic resistance (for example, has not had recent antibiotic use, does not attend daycare, and has not had a recent episode of AOM); Mrs. Bluebird educated about rationale and agrees 2) Recommended increased rest for client when acutely febrile 3) Health teaching to client's mother about appropriate use of acetaminophen (dosage to give, give when febrile or irritable for next 2 days, reassess client after 1 hour to ensure working) 4) Health teaching about acute otitis media disease course (90% of cases recover spontaneously within 72 hours) 5) Avoid flying until symptoms have resolved 6) Acetaminophen 240mg (3mL of 80mg/mL) PO q6h prn; 24mL bottle dispensed 7) Return to clinic in 48–72 hours so client can be reassessed and antibiotics initiated if needed. Return immediately if symptoms worsen, new symptoms appear (for example, vomiting) or if any concerns.
	<i>J. Nurse, RN</i>

APPENDIX B – SAMPLE DOCUMENTATION FOR A COMPREHENSIVE HEALTH ASSESSMENT⁶⁴

Demographic Data: Jane Peacock July 7, 1977, Female, 2500 Anyband, 25 North St. Anyband Canada
 Next of kin: James Peacock 123 456-7890; Harmer
 June 23, 2003 0915

S	CC: “Physical” and “renewal of birth control pills”
	HPI: Well, no health concerns
	<p>Current Health: <i>Medications:</i> Ortho 777 for birth control with no reported problems with adherence, takes multi-vitamin daily; no recreational drugs <i>Smoking:</i> non-smoker <i>Alcohol use:</i> social drinker, about one drink a month <i>Diet:</i> “takes vitamins, doesn’t feel she always eats properly” <i>Immunizations:</i> last Td September 2000; Rubella titre immune Sept. 1998 <i>Allergies:</i> Environmental and bananas – is aware to avoid kiwi and latex products <i>Screening test:</i> annual PAP; does not practice breast self-examination; exposed to second-hand smoke at work <i>Exercise:</i> works out at gym to help deal with day to day stresses at work</p>
	<p>PMH: <i>Childhood illnesses:</i> chickenpox as a child <i>Medical illnesses:</i> tonsillitis 2000, treated with antibiotics; pharyngitis 2001; no hypertension, heart disease, diabetes, cancer, asthma, renal problems, hepatitis <i>Last physical exam:</i> September 2001 <i>Hospitalizations:</i> none <i>Surgeries:</i> colposcopy April/04 for abnormal PAP <i>Accidents or injuries:</i> second-degree burn to arm in 1998 from hot grease at work <i>OBS/GYNE history:</i> gravida 0; LNMP November 24/04; in a monogamous relationship ×3 years; 8 previous sexual partners; no history of STI</p>
	<p>Family History (a genogram also works well and could be included on the face sheet): <i>Parents:</i> 50-year-old father (hypertension, hypothyroid, allergic to dust, cats); 51-year-old mother (alive and well) <i>Paternal grandparents:</i> 75, M: hypertension; 70, F: osteoporosis <i>Maternal grandparents:</i> 72, M: type 2 diabetes; 69, F: basal cell skin cancer (nose) <i>Siblings:</i> brother – GERD (has had negative gastroscopy)</p>
	<p>Personal and Social History:</p> <ul style="list-style-type: none"> • Occupation: server at a Johnny’s restaurant; enjoys her work, friendly atmosphere • Major stressor is concern about abnormal PAP smear and having a colposcopy • States has good relationship with partner, good communication
	REVIEW OF SYSTEMS
	General: young woman with no weight changes, exercises 4×/wk, no change in appetite, feels well
	Integumentary: has a scar on left arm from a burn; a few moles on her back, which she monitors; feels she protects herself well from the sun (with sunscreen and hats) but she does not avoid the sun; gets “hives” when she eats bananas (no respiratory symptoms)

	<p>Head/Neck: <i>Eyes:</i> vision is “good”, saw optometrist Feb 02, 3/12 ago, no problem with night vision, no inflammation, no blurring, no photophobia, no diplopia <i>Ears:</i> no hearing problems, no pain, no discharge, no tinnitus <i>Nose:</i> some clear discharge, denies sinus pain, no epistaxis <i>Mouth & throat:</i> no voice changes, no hoarseness, has sore throat occasionally, has had bouts of tonsillitis and pharyngitis, no dental problems, last dental appointment for cleaning and check-up was within 6 months, states she flosses daily</p>
	<p>Breast: does not perform breast self examination; denies breast lumps, tenderness or nipple discharge</p>
	<p>Respiratory: denies pain, sputum, hemoptysis, wheeze, shortness of breath, or cough</p>
	<p>Cardiovascular: denies chest pains, palpitations, syncope, shortness of breath; no edema, no varicose veins, no leg cramping</p>
	<p>Gastrointestinal: no abdominal pain; no nausea, vomiting or diarrhea; no constipation; no dysphagia or jaundice; no weight loss; denies heartburn</p>
	<p>Genitourinary: denies frequency, dysuria, hematuria, fever, incontinence; regular menstrual cycle q24days; LNMP Nov 24–29/04; no irregular bleeding; uses oral contraception</p>
	<p>Musculoskeletal: states occasional back and feet pain after long work day; no heat, redness, swelling, or stiffness in any joints; no weak or painful muscles</p>
	<p>Neurological: no history of seizures, memory loss, tingling, syncope; no headaches; no visual or hearing changes; no speech changes; no muscle weakness, no tremor, no ataxia; no memory or concentration problems; no bowel or bladder dysfunction</p>
	<p>Mental Health: denies depression, anxiety, panic attacks</p>
O	<p>General: healthy-looking female; well-groomed; appears stated age</p>
	<p>Vital Signs: weight: 50.6 kg; height: 155 cm; B/P: 108/64 (right), 100/64 (left) sitting; temp: 37; pulse: 60 regular; Resp: 18</p>
	<p>Integumentary: pink in colour; a 12×5-cm old scar on left forearm; skin is warm to touch and well-hydrated</p>
	<p>Head/Neck: <i>Head:</i> hair: normal distribution • scalp: no lesions or scaling • skull: normal contour, no tenderness • face: symmetrical, no edema, no lesions, no excessive facial hair <i>Eyes:</i> pupils: PERRLA, fundi-sharp definition with no abnormalities • lids & lashes: no redness or discharge, no lesions seen • no edema, sclera white, conjunctiva clear <i>Ears:</i> pinna: no lesions, no tenderness over tragus or mastoid • canal: no discharge, swelling, redness, tenderness, wax, or foreign body • tympanic membrane: opaque, light reflex seen, landmarks seen, no bulging, no scarring, no fluid, no perforations • hearing: Rinne, Weber, whisper tests, no hearing deficits <i>Nose:</i> no discharge, inflammation, bleeding, deformity; Nares patent; no edema; no deviated septum; no polyps <i>Sinuses:</i> no tenderness of maxillary or frontal sinuses <i>Throat:</i> no redness or exudate; no enlarged tonsils <i>Neck:</i> supple, no enlarged or tender lymph nodes; thyroid not enlarged; no nodules or masses palpated; trachea palpated midline</p>
	<p>Breasts: small in size, symmetrical, no tenderness/lumps/lesions noted, no nipple discharge; no axillary lymphadenopathy</p>

	<p>Respiratory: symmetrical breathing effort; no cyanosis; no scars; no clubbing; no accessory muscle use <i>P:</i> A/P ratio:1:2; no areas of tenderness; no masses; no nodes; equal chest expansion <i>P:</i> resonance throughout <i>A:</i> breath sounds clear to bases with no adventitious sounds</p>
	<p>Cardiovascular: no pulsations or heaves noted <i>P:</i> PMI at 5th ICS, MCL <i>A:</i> S₁ S₂ present, no S₃ S₄, bruits or murmurs; regular rhythm; all peripheral pulses equal bilaterally</p>
	<p>Abdomen: flat, no masses, symmetrical; has a “belly button” piercing with no redness noted <i>P:</i> tympanic; liver 7 cm <i>P:</i> soft; no tenderness; no masses; no hernias; liver edge smooth; spleen not palpable; no CVA tenderness; rectal exam refused <i>A:</i> bowel sounds present in all 4 quadrants, no bruits</p>
	<p>Genitalia: external genitalia: no masses</p> <ul style="list-style-type: none"> • vagina: mucosa moist and pink without lesions, no odour or discharge • cervix: pink, nulliparous • os: smooth, mobile, no cervical excitation • uterus: midline, anteverted, firm, smooth, below symphysis (non-pregnant) non-tender • adnexae: right ovary palpable, “slightly” tender; left ovary not palpable, non-tender, no masses
	<p>Musculoskeletal: no obvious deformities or joint swelling; full range of motion to all extremities; equal muscle strength with and without resistance and equal muscle tone</p>
	<p>Neurological: alert, oriented ×3, deep tendon reflexes +2; symmetrical muscle tone, bulk & power; sensory sensation equal and present bilaterally (face, arms, chest, abdomen and legs); cranial nerves II–XII grossly intact, cerebellar functions intact, Romberg test negative</p>
	<p>Risk factors: previous history of multiple sexual partners; does not wear allergy bracelet; carries heavy trays at work; exposure to second-hand smoke; family history of hypertension; type 2 diabetes; basal cell carcinoma and osteoporosis; previous positive cervical lesion</p>
A	<p>Diagnosis: healthy woman seeking contraceptive management</p>
P	<ol style="list-style-type: none"> 1) Diagnostics: urine dip was negative; pap smear 2) Therapeutics: Ortho 777 (28-day package), one tablet PO od; 3 packages given 3) Health teaching on use of oral contraception, family planning 4) Self breast exam reviewed with client 5) Obtain prescription and submit to NIHB 6) Return to clinic in one year, or sooner of any concerns
<p><i>J. Nurse, RN</i></p>	

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