

ESSENTIALS OF NURSING PRACTICE

4th Edition

^uncorrected proofs^

^uncorrected proofs^

ESSENTIALS OF NURSING PRACTICE

**Edited by
Catherine Delves-Yates**

Advisory Editors:

**Karen Elcock, Carol Hall,
Dorothy Kupara and
Steve Trenoweth**

4th Edition

 **Sage**

3rd Floor
HYLO
103–105 Bunhill Row
London, EC1Y 8LZ
UK

2455 Teller Road
Thousand Oaks
California 91320

10th Floor, Emaar Capital Tower
2 MG Road, Sikanderpur, Sector 26
Gurugram, Haryana – 122002
India

8 Marina View Suite 43-053
Asia Square Tower 1
Singapore 018960

Editor: Laura Walmsley
Development editor: Jessica Moran
Assistant editor: Pippa Wills
Production editor: Imogen Roome
Copyeditor: Sarah Bury
Proofreader:
Indexer:
Marketing manager: Ruslana Khatagova
Cover design: Sheila Tong
Typeset by: C&M Digital (P) Ltd, Chennai, India
Printed in the UK

Editorial arrangement © Catherine Delves-Yates 2027

Chapter 1 © Catherine Delves-Yates, Karen Elcock, Carol Hall, Steve Trenoweth 2027
Chapters 2, 12, 32, 40 © Catherine Delves-Yates 2027
Chapter 3, 4 © Gabrielle Thorpe 2027
Chapter 5 © Ruth Northway and Ian Beech 2022; Updates to Chapter 5 © Carol Hall, Sarah Abbott, Dawn Ritchie 2027
Chapter 6 © Graham Avery 2022; Updates to Chapter 6 © Catherine Delves-Yates 2027
Chapter 7 © Karen Elcock 2027
Chapter 8 © E. Jane Blowers 2027
Chapter 9 © Nickey Rooke, Jacqueline Phillips 2022; Updates to Chapter 9 © Nickey Rooke 2027
Chapter 10 © Fiona Everett, Wendy Wright 2027
Chapter 11 © Carol Hall 2027
Chapter 13 © Katrina Emerson, Ruth Northway 2022 Updates to Chapter 13 © Tom Holmes 2027
Chapter 14 © Rebekah Hill 2027
Chapter 15 © Karen Elcock, Kimberley Byrnes 2022; Updates to Chapter 15 © Karen Elcock
Chapter 16 © Steve Trenoweth, Sue Baron 2027
Chapter 17 © Mary McGee 2027
Chapter 18 © Jill Barnes, Robert Jenkins, Claire Brockwell 2022; Updates to Chapter 18 © Claire Brockwell 2027
Chapter 19 © Gemma Hurley 2022; Updates to Chapter 19 © Val Acop Basil
Chapter 20 © Katie McLaughlin 2027
Chapter 21 © Charlene Lobo, Daryl Evans, Helen Walker, Coralie Roll 2022; Updates to Chapter 21 © Coralie

Roll
Chapter 22, 23 © Rose Gallagher 2022; Updates to Chapter 22 and 23 © Monet Marinas and Carli Whittaker
Chapter 24 © Caroline Dobson, Trevor Simpson 2022; Updates to Chapter 24 © Caroline Dobson
Chapter 25 © Ann Kettle 2022; Updates to Chapter 25 © Val Acop Basil
Chapter 26 © Alexandra Carlin 2027
Chapter 27 © Michelle O'Reilly, David Best 2022; Chapter 27 updates © Bill Bower and James Coughlan
Chapter 28 © Sara Morgan 2027
Chapter 29 © Carol Hall, Christina Roulston 2022; Updates to Chapter 29 © Christina Roulston
Chapter 30 © Kate Goodhand, Jane Ewen 2022; Updates to Chapter 30 © Deborah Rainey
Chapter 31 © Mairead Collie, David J. Hunter 2022; Updates to Chapter 31 © Aby Mitchell
Chapter 33 © Maria Parry 2027
Chapter 34 © Siobhan McCullough 2022; Updates to Chapter 34 © Alexandra Carlin 2027
Chapter 35 © Hanneke Wiltjer 2022; Updates to Chapter 35 © Coral Drane
Chapter 36 © Janet Ramjeet, Catherine Delves-Yates 2022 Updates to Chapter 36 © Catherine Delves-Yates 2027
Chapter 37 © Ruth Northway; Updates to Chapter 37 © Chris Yuill 2027
Chapter 38 © Charlene Lobo, Coralie Roll 2022; Updates to Chapter 38 © Coralie Roll 2027
Chapter 39 © Siobhan McCullough 2022; Updates to Chapter 39 © Chris Yuill and Will Ball

Apart from any fair dealing for the purposes of research, private study, or criticism or review, as permitted under the Copyright, Designs and Patents Act, 1988, this publication may not be reproduced, stored or transmitted in any form, or by any means, without the prior permission in writing of the publisher, or in the case of reprographic reproduction, in accordance with the terms of licences issued by the Copyright Licensing Agency. Enquiries concerning reproduction outside those terms should be sent to the publisher.

Library of Congress Control Number: 2026934246

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

ISBN 978-1-5296-8566-4

ISBN 978-1-5296-8565-7 (pbk)

Contents

<i>Guide to your book</i>	ix
<i>Online resources</i>	xi
<i>Notes on the editor and contributors</i>	xiii
<i>Preface: Reflections...</i>	xxv
<i>Acknowledgements</i>	xxvii
 Introduction	 1
 Part A Learning to be a Nurse	 3
1 What is nursing and what is a nurse? <i>Catherine Delves-Yates, Karen Elcock, Carol Hall, Ruth Northway, Dorothy Kupara and Steve Trenoweth</i>	5
2 Being a nursing student <i>Catherine Delves-Yates</i>	21
3 Reflection and evidence-based practice <i>Gabrielle Thorpe</i>	39
4 Academic writing and assessment <i>Gabrielle Thorpe</i>	61
 Part B Professional Practice	 79
5 Ethics <i>Ruth Northway and Ian Beech, updated by Carol Hall, Dawn Ritchie and Sarah Mabbott</i>	81
6 Law <i>Graham Avery, updated by Catherine Delves-Yates</i>	95
7 Accountability and professionalism <i>Karen Elcock</i>	111
8 Resilience <i>E. Jane Blowers</i>	125
9 Leading change to improve care quality <i>Nickey Rooke</i>	139

Part C Fundamentals of Nursing Care 155

- 10 Delivering effective care 157
Fiona Everett and Wendy Wright
- 11 Introduction to nursing theory 175
Carol Hall
- 12 The essentials of nursing care 191
Catherine Delves-Yates
- 13 Patient, service user, family and carer perspectives 211
Katrina Emerson and Ruth Northway, updated by Tom Holmes
- 14 Assessment, planning, implementation and evaluation (APIE):
The Process of Nursing 225
Rebekah Hill
- 15 Core communication skills 241
Karen Elcock and Kimberley Byrnes
- 16 Communication and interpersonal skills in challenging circumstances 251
Steve Trenoweth and Sue Baron
- 17 Every person matters 273
Marie McGee
- 18 Record-keeping and documentation 293
Jill Barnes and Robert Jenkins, updated by Claire Brockwell
- 19 Clinical decision making 309
Val Acop Basil
- 20 Safeguarding 327
Katie McLaughlin
- 21 Promoting health 345
Charlene Lobo, Daryl Evans and Helen Walker, updated by Coralie Roll

Part D Skills for Nursing Care 367

- 22 Infection prevention and control (IPC) 369
Rose Gallagher, updated by Monet Marinas
- 23 Aseptic technique and specimen collection 393
Rose Gallagher, updated by Monet Marinas

24	Clinical measurement <i>Caroline Dobson and Trevor Simpson</i>	415
25	Pain management <i>Val Acop Basil</i>	449
26	Skin integrity <i>Alexandra Carlin and Alison Parnham</i>	477
27	Safe movement of people <i>Michelle O'Reilly and David Best, updated by James Coughlan and Bill Bower</i>	503
28	Emergency care <i>Sara Morgan</i>	523
29	Medicines administration <i>Carol Hall, updated by Christina Roulston</i>	545
30	Assisting people with their nutritional needs <i>Kate Goodhand and Jane Ewen, updated by Deborah Rainey</i>	565
31	Assisting people with their elimination needs <i>Mairead Collie and David J. Hunter, updated by Aby Mitchel and Barry Hill</i>	591
32	Assisting people with their hygiene needs <i>Catherine Delves-Yates</i>	617
33	Care after death <i>Maria Parry</i>	639
Part E Context of Nursing Care		655
34	Introduction to the organisation and settings of care <i>Alexandra Carlin and Nigel Horner</i>	657
35	Introduction to interprofessional working <i>Hanneke Wiltjer, updated by Coral Drane</i>	675
36	Introduction to the psychological context of nursing <i>Janet Ramjeet, updated by Catherine Delves-Yates</i>	687
37	Introduction to the sociological context of nursing <i>Ruth Northway, updated by Chris Yuill</i>	707
38	Introduction to public health <i>Coralie Roll</i>	723

39	Introduction to health policy and the political context of nursing <i>Siobhan McCullough, updated by Will Ball and Chris Yuill</i>	739
40	Introduction to the global context of nursing <i>Catherine Delves-Yates</i>	761
	<i>References</i>	773
	<i>Index</i>	000

uncorrected proofs

Guide to your book

The features in this book have been carefully designed to support you on the journey to becoming a nurse. We hope you enjoy the book and that it helps you succeed in your degree and future career. Good luck!

Case studies appear throughout the chapters and put theory into practice. They provide examples from different fields of nursing and really make you think.

Activities support your learning and deepen your understanding on key topics. They help develop transferrable skills like critical thinking, reflection and evidence-based practice.

Answers to the activities in the book are available on the SAGE website.

Voices from people receiving care, nursing students and practitioners appear throughout the book. They will help you relate to some of the challenges you might face during placements and hear how fellow students have managed to overcome similar situations.

The book has a full section devoted to **clinical skills**. It provides clear **step-by-step** boxes that walk you through many of the core nursing procedures you will encounter during practice learning placements, and **A&P link** boxes that go into detail on elements of anatomy and physiology.

^uncorrected proofs^

Online resources

Lecturers and educators using the book have access to a vast bank of additional teaching materials available at: <https://study.sagepub.com/essentialnursing4e>

For lecturers and educators:

- Multiple choice questions for each chapter
- Short answer questions for some chapter
- Patient case studies
- Presentation slides for each chapter for download and use within teaching
- Assignable video links with discussion questions
- The resources have been integrated into a 'teaching guide' that combines the resources into a comprehensive resource.

For students:

- Answer guidance to all of the activities and case studies in the book is available for students.

^uncorrected proofs^

Notes on the editor and contributors

Editor

Catherine Delves-Yates is an experienced nurse and lecturer at the School of Health Sciences, University of East Anglia, UK. She began her nursing journey at the Nightingale School of Nursing in London and has since gained extensive clinical experience in adult and paediatric critical care across the UK. Her career has also taken her internationally, where she has taught and practiced nursing in America, Africa and Nepal.

Driven by a passion for ensuring that nurses are equipped with the knowledge, skills and professionalism required to deliver compassionate person-centred care, Kate has authored and edited several widely used nursing textbooks. Her specialist areas of expertise include person-centred care and reflective practice.

Her doctoral research explored how nursing students' perceptions of health and illness evolve throughout their pre-registration nursing programmes, contributing valuable insights into the development of future nurses.

Advisory editors

The following advisory editors helped work to ensure this book contained accurate and equal coverage of all fields of nursing in a variety of settings:

Learning disabilities: Dorothy Kupara, University of West London

Child nursing: Carol Hall, University of Nottingham

Mental health: Steve Trenoweth, University of Bournemouth

Adult nursing: Karen Elcock, formerly Kingston University.

Contributors

Graham Avery is a former lecturer in the School of Health and Social Care at the University of Essex. Graham worked as a nurse in a variety of adult acute settings, specialising in general surgery.

Will P. Ball is a Chancellor's Fellow at Robert Gordon University and an Honorary Researcher with NHS Grampian. He is a Social Epidemiologist with a research focus on population health and health inequalities. His doctoral research used large-scale administrative data to examine self-rated health and socioeconomic inequalities among Registered Nurses, drawing on both

quantitative methods and social theory. Prior to his academic career, he worked as a Registered Nurse in cardiac catheterisation laboratories, experience which continues to shape his interest in linking research, policy and clinical practice. Will's research centres on understanding and reducing unfair and avoidable differences in health, with interests in children's mental health and socioeconomic inequalities. His teaching spans quantitative research methods, population health and the social determinants of health, with an emphasis on helping nurses and other healthcare professionals understand how evidence and policy can be used to advocate for improved health outcomes at the population level.

Jill Barnes is a former Academic Manager and Head of Professional Regulation at the University of South Wales and Senior Fellow of the Higher Education Academy. She has had extensive experience in the development of pre-registration nursing curricula, quality enhancement and placement learning.

Sue Baron is Principal Academic in Adult Nursing at Bournemouth University and former lead of the MSc Adult Nursing programme. A Registered Nurse and Senior Fellow of the Higher Education Academy, she is an experienced educator supporting MSc, BSc (Hons) and Registered Nurse Degree Apprenticeship programmes. Her work focuses on preparing nurses for complex and emotionally challenging clinical situations. Sue's leadership includes innovative co-creation projects involving people with lived experience, and supervision of doctoral students exploring health and care experiences to inform improvement. Recognised through multiple awards for teaching and collaboration, her research centres on quality, safety and person-centred practice, with projects on nurse leadership, simulation-based learning and palliative care. Her work is grounded in evidence-based approaches and interdisciplinary collaboration to promote compassionate, person-centred care and meaningful impact on student learning.

Val Acop Basil is a nurse lecturer with a clinical background in adult intensive care, paediatric and neonatal intensive care, and specialist transport nursing. She currently teaches across undergraduate nursing programmes at the University of West London, with a particular focus on anatomy and physiology, clinical decision making and research literacy. Val is deeply interested in how nurses learn to think, decide and act in complex clinical environments, especially under pressure. Alongside her teaching role, Val is the founder of Project VALIFY, an innovative approach that uses gamification, simulation and creative design to support clinical reasoning, confidence and engagement in nursing students. Her work bridges theory and practice, blending evidence-based frameworks with experiential learning approaches.

Ian Beech has held clinical posts in drug and alcohol abuse, general surgery, an elderly mentally ill assessment unit and in community psychiatry. For many years he was subject lead for mental health at the University of Glamorgan/University of South Wales and worked at Swansea University, where he combined the teaching of undergraduate mental health nursing students with post-graduate supervision.

David Best trained as a Registered Mental Health Nurse (RMN) and initially worked in forensic mental health services. He moved into learning and development and has been a Manual Handling Area Lead at Napier University, delivering core handling skills to nursing and therapy students.

E. Jane Blowers began her career as a Registered General Nurse (RGN), before completing mental health nurse education, qualifying as a Registered Mental Health Nurse (RMN). Working in acute mental health services, she developed a wide range of skills and gained experience in mental health practice, team management and leadership. It was during this time that she completed a BSc (Hons) in Health Studies. In 2001, Jane became a lecturer in mental health nursing at the University of East Anglia (UEA). While working at UEA, she completed an MA (Higher Education) and became a Doctor of Education (EdD). Her previous academic leadership roles have included Course Director, School Director of Pre-registration Programmes, Professional Lead for Pre-registration Nursing and Faculty of Medicine and Health Sciences Associate Dean Learning, Teaching and Quality. In 2025, Jane retired from a highly rewarding career in health. She remains a strong advocate for high-quality healthcare and staff wellbeing.

Bill Bower is an NMC dual-registered adult and children's nurse who works on the BSc Nursing programme at the University of Nottingham. He completed his Bachelor of Nursing at the University of Sydney in 1996, then working on a rotation programme at Sydney Children's Hospital before specialising in paediatric intensive care. He continued working in paediatric intensive care after moving to the United Kingdom in 1999 and developed expertise as an ECMO (extra-corporeal membrane oxygenation) specialist at Glenfield Hospital. Bill later transitioned into health-care education in 2011. He held roles in clinical skills at the University Hospitals of Leicester NHS Trust, before serving as Education Lead for Operating Theatres at Nottingham University Hospitals NHS Trust. He now works as a Teaching Associate on the University of Nottingham's Nursing programme, where he contributes to the development of students across both child and adult fields of nursing.

Claire Brockwell is Lecturer in Nursing Sciences at the University of East Anglia. Claire was a 'Why?' child and her parents, particularly her mother, encouraged this trait rather than quashing it. In adulthood, it became a skill that enabled Claire to enquire into, seek to understand and help to resolve short-term and longer-term problems in diverse environments, including large-scale leadership, finance and project management. Nurturing innovation skills in others and overlaying that with an understanding of the importance of governance and strategy allowed her to coordinate a review board for projects in business and then, following nurse training, to transfer those skills to nurse management of a research team in the National Health Service. Claire enjoys the continually evolving nature of innovation in the form of quality improvement via service improvement and research. As a nurse, meeting people's needs and reducing inequalities in care is very rewarding. Claire's doctoral study was based on collaboratively developing and testing an intervention relating to empowering self-management in chronic disease. Now a lecturer in health sciences, Claire loves to kindle the flame of curiosity and the ability to manage change for patient benefit in our future health and social care professionals.

Kimberley Byrnes is an adult field nurse and a former lecturer at Kingston University who was a member of the child and young persons field teaching team.

Alexandra Carlin is a Programme Lead at Lincoln Bishop University and an accomplished qualitative researcher, ethnographer and nurse educationalist. In her current role, she leads and delivers teaching and learning for undergraduate students in health and social care, as well as postgraduate learners specialising in leadership and management. As a registered adult nurse,

she holds full professional registration alongside a recordable specialist practice qualification in District Nursing. Alex has presented her research internationally and continues to contribute actively to research and discourses in nursing, health and social care. She has previously held academic posts at the University of Nottingham and the University of Lincoln. Alongside her academic commitments, Alex maintains clinical practice through an honorary position in a GP surgery.

Mairead Collie has been a registered nurse for over 35 years, specialising in intensive care. With a passion for teaching and supporting others, Mairead has worked as a practice education facilitator, supporting and advising Practice supervisors on their teaching and learning abilities within the practice learning environment. Mairead is a former lecturer at Glasgow Caledonian University.

James Coughlan is a Physiotherapy Lecturer at the University of Nottingham, specialising in musculoskeletal conditions, assessment and treatment. He holds a BSc and MSc in Physiotherapy, a Postgraduate Certificate in Higher Education, and is a Fellow of the Higher Education Academy. A practising physiotherapist since 2008, James has worked across the NHS, the Ministry of Defence, sports injury rehabilitation and Nuffield Health, where he contributed to both clinical practice and clinical governance. He has also supported the development of emerging physiotherapists through his work as a clinical placement educator. James' teaching is shaped by extensive frontline experience and a commitment to evidence-informed practice. He is particularly passionate about simulation-based learning and its role in building confidence, clinical reasoning and safe, high-quality patient care. He continues to combine academic leadership with a dedication to advancing excellence in musculoskeletal physiotherapy education.

Caroline Dobson is the Assistant Director for Education and Standards at the Nursing and Midwifery Council (NMC), where she leads key areas of regulatory policy, professional standards and quality assurance across nursing and midwifery education in the UK. Prior to this, she was a Senior Lecturer and Programme Lead for BSc (Hons) Registered Nurse Degree Apprenticeship at the University of Lincoln. Caroline qualified as a Registered Nurse in 2002 while working for the Royal Air Force. She specialised in Emergency Nursing and worked in various Emergency departments nationally until making the move into community nursing in 2012. Caroline also has experience of working in primary healthcare and has a keen interest in palliative care. In her current role, Caroline leads and teaches modules across the pre-registration nursing programmes. Caroline received a Higher Education Fellow and a PgCert in Clinical Teaching and Practice Education in 2020.

Coral Drane graduated from the University of East Anglia (UEA) as a Registered Nurse in 2014, following a 20-year career in Further Education. She is an NMC Registered Nurse Teacher and a Fellow of the Higher Education Academy. She began her nursing career in Cardiology at the Norfolk and Norwich University Hospital (NNUH). In 2015, she combined clinical practice with education, first as an Associate Tutor and later as an Adult Nurse Lecturer at UEA, while continuing part-time clinical work in Cardiology. In 2020, she chose to focus fully on her clinical role and in 2021 moved into an educational post at NNUH as a Practice Development and Education Nurse, a role she continues to hold. She is also an Honorary Associate Professor at UEA and works part-time with the Open University as a Practice Tutor and Academic Assessor. Coral is passionate about education, cardiology, interprofessional collaboration and reflective practice.

Karen Elcock is a former Deputy Head of School and Head of Programmes for pre-registration nursing at Kingston University. While there, she acted as a mentor to female staff on the university Equality Mentoring Scheme and as a role model for women in higher education as part of the Aurora Leadership Foundation for Higher Education. She has authored a wide range of nursing textbooks and journal articles with a focus on practice education. By background, she was a critical care nurse. Recently, following an unexpected and lengthy stay in intensive care as a patient, she has spoken at a number of conferences about her experience as a critically ill patient, made a video of her experience as a feedback tool for critical care staff and is a committee member on a support group for patients and relatives who have experienced intensive care.

Katrina Emerson is a qualified Adult Nurse who has worked for many years in sexual health and HIV. Katrina joined the University of East Anglia in 2003 and was involved with the teaching of reproductive and sexual health for undergraduate and postgraduate programmes. As a former Course Director for the BSc (Hons) Adult Nursing Degree programme, Katrina supported nursing students both clinically and academically as they progressed through their degree. In 2025, Katrina returned to clinical practice, taking her extensive skills and knowledge back to the frontline for the direct benefit of patients.

Daryl Evans is a former associate professor at Middlesex University. Prior to this, Daryl held a variety of positions as a nurse and health-promotion specialist.

Fiona Everett is currently a nurse lecturer within pre-registration-level nursing programmes with teaching, coordination and practice responsibilities. Fiona is also a mentor for the Postgraduate Certificate in Teaching and Learning in Higher Education and is a Higher Education Senior Fellow. She has a wide range of clinical experience, including midwifery, district nursing and research project management within primary care. She has particular interests in clinical skills, dementia care and developing contemporary, supportive approaches to nurse education. She has published in these areas in nursing journals and books.

Jane Ewen is a former Nurse Director (Excellence and Innovation) in NHS Grampian, providing strategic corporate nursing and professional leadership through innovation and nursing excellence to drive strategic influence, transformation, workforce planning, education and research. Her previous roles include Chief Nurse for Practice Education and Nurse Consultant (Nutritional Care).

Rose Gallagher has provided strategic leadership and specialist professional advice to the Royal College, its members and key stakeholders across the UK on Infection Prevention and antimicrobial resistance (AMR) and the implications for nurses and nursing. Her portfolio also included sustainability, and she leads the College's professional nursing activity on sustainability. Rose was awarded an MBE in 2016 for services to Infection Prevention and Control in her role at the Royal College.

Kate Goodhand is a former adult nursing lecturer at the School of Nursing, Midwifery and Paramedic Practice at Robert Gordon University, Aberdeen. She is a Senior Fellow of the Higher Education Academy. Kate's nursing background was in medical care of the elderly wards, moving on to the role of night coordinator, covering the hospital during out-of-hours.

Carol Hall is an Emeritus Professor in Nursing Education at the University of Nottingham. Carol continues to maintain an academic profile through writing, occasional teaching and support of colleagues. She also participates part-time in community nursing practice, specialising in aspects concerning health promotion and illness prevention. Carol's PhD study explored nurse preparation and practice in administering medicines for children, and subsequent post-doctoral research included work with a national team to develop a benchmark standard for calculation assessment at the point of nursing registration.

Barry Hill is Professor in Nursing and Critical Care Practice and Associate Head of School within the School of Healthcare and Nursing Sciences at Northumbria University. He holds a PhD with a research focus on hermeneutic phenomenology and professional identity theory and is a Senior Fellow of the Higher Education Academy. Barry is an academic and scholar who has made a sustained impact through books, book chapters and peer-reviewed journals. His work centres on critical care and advanced clinical practice, alongside leadership in nursing. He also serves as a Governor within the NHS and holds Consultant and Clinical Editor roles across national and international journals.

Rebekah Hill is an Associate Professor of Health Education in the Norwich Medical School at the University of East Anglia, where she works as the Deputy head of Medical Education. Rebekah worked as a nurse in Gastroenterology and Hepatology, Critical Care and Acute Medicine for many years, completing her PhD on the Experience of Living with Hepatitis C.

David J. Hunter is a former lecturer in Nursing and Health Care at the University of Glasgow. Before moving into education, David spent nearly ten years as an emergency department nurse and two as a practice education facilitator.

Tom Holmes is an Adult Nurse, whose career has been grounded in person-centred values and the belief that care should be shaped by the voices of those who receive it. Tom's experience across community and acute environments exposed him to a wide range of patient journeys, each contributing to his understanding of meaningful, compassionate practice. Transitioning into Clinical Education allowed Tom to support others in developing reflective, evidence-informed approaches to care. He now works as a Lecturer in Nursing at the University of East Anglia while completing a Master's in Clinical Education. This role enables Tom to guide nursing students and health science learners as they form their professional identities and prepare to deliver high-quality, empathetic care. Listening deeply to patients, families and carers has remained a constant thread throughout Tom's career, shaping his values and reinforcing his commitment to nurturing practitioners who prioritise dignity, respect and authentic partnership.

Nigel Horner is Honorary Professor of Social Work and Interprofessional Education at the University of Lincoln, where he was formerly Head of the School of Health and Social Care. He began his professional career in residential child care, before qualifying in social work and working in mental health, CAHMS, fostering and adoption, training, and policy development, before taking up academic posts. Nigel is currently researching historic social welfare formations in Lincolnshire.

Robert Jenkins is a former academic manager and subject specialist for learning disability, leading teaching across a number of undergraduate and postgraduate programmes and modules.

Dorothy Kupara is an Associate Professor and Professional Lead for Children's and Learning Disabilities Nursing, and Course Leader for Learning Disability Nursing at the College of Nursing, Midwifery and Healthcare, University of West London (UWL). She completed her PhD on the roles of Learning Disabilities Acute Liaison Nurses in hospital settings. Since beginning her career in the early 2000s, she has worked across residential, community and acute services as a Registered Nurse in Learning Disabilities, including roles as an acute liaison nurse and Lead Nurse in a Community Learning Disabilities Team. She is a qualified non-medical prescriber and has contributed to academic practice as an External Examiner, peer reviewer and collaborator on workforce development initiatives across London. Nationally, she has been expert advisor to NHS England and HEE (Health Education England) projects on acute liaison nursing. At UWL, she teaches across pre- and post-registration programmes and supervises undergraduate and doctoral students. Her interests include advanced practice, prescribing, research, leadership, digital health and the wellbeing of people with learning disabilities.

Charlene Lobo is a former senior lecturer and academic lead for practice education at the School of Health Sciences, University of East Anglia. She worked in nurse education for nearly two decades, and prior to that as a health visitor.

Sarah Mabbott qualified as a nurse in 2008, starting her nursing career in an acute trust working on a medical ward. She moved into primary care in 2013 and discovered that practice nursing was her passion. Sarah completed the BSc in Practice Nursing in 2014, moved into a more strategic role in 2022, becoming Head of Nursing, Quality and Patient Safety for an independent company working exclusively with NHS patients within the community. This role ignited a passion for quality and patient safety, which inspired Sarah to undertake the MSc in Quality and Patient Safety, which she completed, with distinction, in 2025.

Monet Marinas is an accomplished Infection Prevention and Control (IPC) leader with more than 25 years of experience across the independent and charity health sectors. Since becoming an IPC Lead Nurse in 2008, she has built a reputation for strategic insight, compassionate leadership and patient safety. She holds a Bachelor's degree in Advanced Practice IPC and a Master's degree in Healthcare Associated Infection Control, reflecting her academic and professional grounding. In 2024, Monet joined the Royal College of Nursing as the Professional Lead for IPC, where she works to embed infection prevention principles across nursing practice on a national scale. As a passionate advocate for education, collaboration and workforce development, Monet is known for building strong, motivated teams and supporting IPC practitioners through learning and networking. Her work with stakeholders focuses on pragmatic, evidence-informed approaches to IPC delivery, shaping safer care environments and empowering nurses to lead with confidence.

Siobhan McCullough is a former Lecturer in Nursing at Queen's University Belfast. Her research focuses on nursing and politics, health policy and nursing and care in the community. In her research, she has explored nurses' political participation and how nurses interact with the political system. She is a passionate advocate for political education for nurses to enable and equip them to contribute to and influence healthcare policy making.

Marie McGee is an experienced nurse academic with a clinical background in urology and rheumatology advanced practice. She is an Associate Professor leading the professional doctorate programme

and postgraduate teaching in long-term conditions, clinical decision making and qualitative research, including interpretative phenomenological analysis. Her PhD explored older people's experiences of urgent and emergency care, with a particular focus on person-centred communication and relational practice. As a Senior Fellow of Advanced HE, Marie has a strong track record in curriculum innovation, interprofessional teaching and research supervision. She has also worked as Student Experience Lead, developing a clear commitment to embedding equality, diversity and inclusivity into everyday nursing practice to support nurse education. Her research includes national studies on graduate entry nursing, nurse triage decision making and patient lived experiences of polymyalgia rheumatica. Marie brings together clinical credibility, academic leadership and a passion for compassionate, evidence-based and inclusive nurse education.

Katie McLaughlin is an Associate Professor in the School of Health Sciences at the University of East Anglia lecturing across pre- and post-registration provision. She has worked as a Health Visitor in a variety of settings and specialised as a Safeguarding Children trainer and Specialist Nurse for Safeguarding Children in both Commissioning and Foundation Trusts. She is the Safeguarding Children Lead for the School, and her research interests are female genital mutilation in diaspora communities, child sexual exploitation as well as public health and maternal and child health.

Aby Mitchell is a Senior Lecturer and Faculty Lead for Simulation at King's College London. She has extensive experience in simulation-based learning, immersive technologies and advancing inclusive, evidence-informed nursing education. Aby has contributed to national and international projects across acute, community and mental health settings, supporting innovation in teaching, assessment and professional development. Her work focuses on improving patient outcomes through high-quality education, compassionate practice and future-focused healthcare training.

Sara Morgan is a Senior Lecturer in Advanced Practice and Specialist Lead for Interprofessional Education at the University of South Wales. She is an Advanced Nurse Practitioner with extensive experience in emergency care, clinical practice and education. Sara teaches across pre- and post-registration nursing programmes, including Minor Illness at Master's level, and leads innovative simulation-based learning initiatives, including large-scale interprofessional Hydra simulations. These initiatives enable students from multiple healthcare professions to develop clinical competence, teamwork and patient-centred care. Her work emphasises health inequalities, evidence-based practice and experiential learning, ensuring education translates directly into improved patient outcomes. In addition to her academic role, Sara contributes to national professional networks, including the RCN Emergency Care Forum, helping to shape emergency nursing standards and practice. She is particularly passionate about advancing emergency care, improving clinical outcomes and supporting healthcare teams to deliver high-quality, patient-centred services in urgent and critical situations.

Ruth Northway is a former professor of learning disability nursing at the University of South Wales. Prior to working in nurse education, she worked with people with learning disabilities in both residential and community settings.

Michelle O'Reilly is an internationally recognised expert in using simulated practice to facilitate learning. Michelle is a former lecturer in adult nursing, academic lead for simulation and

clinical skills and the Clinical Director of the Simulation and Clinical Skills Centre in the School of Health and Social Care at Edinburgh Napier University.

Alison Parnham is a Clinical Nurse Specialist in Tissue Viability and an Associate Teacher at the University of Nottingham, bringing over 40 years of nursing experience, including more than 30 years specialising in tissue viability across primary and secondary care. She has played a key role in undergraduate and postgraduate education, developing and delivering accredited wound healing and repair programmes at Bachelor's and Master's level. Alison has contributed extensively to local policy and clinical guideline development, promoting consistent, evidence-based practice aligned with national standards. She has presented widely at national and international conferences and collaborated with industry partners to support innovation in wound care. Holding a BSc (Hons) in Tissue Viability and an MSc in Health and Social Care, Alison has also reviewed an international consensus document on wound debridement. Her publications reflect her specialist expertise in biofilm management and hard-to-heal wounds.

Maria Parry is Programme Manager for the National Palliative and End of Life Care Programme in NHS Wales, where she works across NHS Wales, Welsh Government, the third sector and the public to improve outcomes and experiences for people requiring palliative and end of life care. A Registered General Nurse by background, she has four decades of experience spanning clinical practice, specialist palliative care, leadership, education and national programme development. She holds a Master's degree in Palliative Care, is a Registered Nurse Teacher and a Fellow of the Higher Education Academy. Prior to her current role, Maria held senior academic and leadership posts at the University of South Wales, where she led undergraduate nursing programmes and palliative care education. She has published widely in peer-reviewed journals, contributed to textbooks and is an experienced journal reviewer. Her professional interests include end of life care education, care after death, decision making and system-level improvement in palliative and end of life care.

Deborah Rainey is a Senior Nurse Lecturer Queens University Belfast. Her clinical experience is predominantly in caring for cardiothoracic or bowel surgical patients. Debbie's teaching is based in acute adult nursing and she has a special interest in practice learning and development of practical nursing skills. She is the lead for the postgraduate entry MSc pre-registration nursing programme and also coordinates and teaches post-registration modules on teaching and learning in practice.

Janet Ramjeet is a former lecturer in nursing, teaching psychology to undergraduate and postgraduate nurses and allied health professionals. Her background is in adult and mental health nursing.

Dawn Ritchie is an Associate Professor in Nursing Children and Young People at the University of Nottingham. Her work focuses on enhancing children's nursing education, improving placement experiences and supporting the delivery of safe, compassionate child- and family-centred care. Dawn has a particular scholarly interest in legal and ethical issues in nursing, with a focus on end-of-life decision making within paediatric critical care settings. Her work explores how children, families and professionals navigate complex treatment decisions and how education can better prepare nurses for these challenging aspects of practice.

Coralie Roll has been a registered nurse for over 30 years. She is an Associate Professor in Nursing Studies in the School of Health Sciences at the University of East Anglia, and has expertise in curriculum design, meeting professional body standards and quality assurance requirements. Her professional interests include professionalism, professional identity, health promotion and public health. Prior to working at UEA, Coralie worked in the NHS in a range of roles, including Health Care Assistant, Adult Nurse, Midwife and as a Specialist Community Public Health Nurse - School Nursing.

Nickey Rooke is an Associate Professor in the School of Health Sciences at the University of East Anglia. Her nursing career began over 30 years ago, and since qualifying Nickey has worked predominantly in Older People's Medicine and in the community, where Nickey worked as a District Nursing Sister for several years before moving into Higher Education. Nickey is involved in teaching across a variety of nursing programmes, including nursing apprenticeships, undergraduate, post-graduate and post-registration programmes, and is currently Course Director for MSc Adult Nursing and Lead Course Director for pre-registration nursing. She was awarded a PhD in Nursing Studies from the University of Essex in 2018, and her interests include patient and public involvement in practice assessment, quality improvement, community nursing, leadership and health education.

Christina Roulston is a senior lecturer and programme lead for the Nursing Associate foundation degree programme at the University of Chester. Prior to moving into education, she worked in adult nursing, in both primary and secondary care settings. Her key interests are safe medicine management. She is the co-author of *Medicines Management for Nursing Associates* (Sage, 2024).

Trevor Simpson is a former associate professor in the School of Health and Social Care, College of Social Science, University of Lincoln. He has a clinical background in respiratory, cardiac and intensive care nursing over a 25-year period. His main interests are skills development for pre-registration nursing students, particularly relating to cardiac and respiratory nursing care. He is also interested in innovation in teaching and learning environments and the skills acquisition of teachers. He is published on areas of research including interprofessional learning in a health and social care context, innovation in the use of technology to enhance simulation learning, preparing the future nursing workforce, and clinical skills acquisition in airway management.

Gabrielle Thorpe is a Professor of Professional Development in Health Sciences and Deputy Head (Learning and Teaching Enhancement) of the School of Health Sciences at the University of East Anglia. Gabby's clinical and research background is in colorectal and stoma care nursing, an area in which she has specialised for 30 years. As an academic since 2009, Gabby has focused on supporting health professional students and registered practitioners to develop confidence and capability in academic and research skills, applying these capabilities to their own professional development, their leadership and development of others, and to the improvement of healthcare services and patient care.

Steve Trenoweth has been a mental health nurse for 34 years. He has worked in a wide variety of mental health settings before entering higher education in 1999. He is currently a Principal Academic in Mental Health Nursing at Bournemouth University. He has authored several books, chapters and articles in mental health care, and is an Editorial Board member of the *British Journal*

of Mental Health Nursing. Steve is a UKCGE Recognised Research Supervisor and an Associate Fellow of the British Psychological Society. His current research interests include ecological mental wellbeing, positive mental health, health promotion and recovery. He is a visiting Professor at the Bern University of Applied Sciences in Bern, Switzerland, and leads the Psychosocial and Mental Health theme at the Centre for Wellbeing and Long-Term Health based at Bournemouth University.

Helen Walker is a former senior lecturer at the University of the West of Scotland. She also worked as a consultant nurse with the Forensic Network.

Hanneke Wiltjer is a former lecturer in nursing at HZ University of Applied Sciences in Vliissingen, the Netherlands. Hanneke's research has focused on the interdisciplinary assessment of older people who have been admitted to hospital, and on the role of nursing staff within this complex process.

Wendy Wright is a former lecturer in Adult Nursing, teaching to undergraduate and post-graduate nursing student at the University of the West of Scotland. She had a wide range of acute clinical experience, including infectious diseases, stroke and elderly admissions. Wendy had particular interests that included clinical skills education for nursing students, the student experience, dementia care and skills.

Chris Yuill is Professor of Sociology at Robert Gordon University. He has served as both Trustee and Chair of the British Sociological Association. His research focuses on health inequalities, the role of alienation and the social determinants of well-being, and he has published widely in these areas. He is also co-author, with Anne-Marie Barry, of the internationally successful textbook *Understanding the Sociology of Health: An Introduction*, now in its sixth edition.

^uncorrected proofs^

Preface: Reflections...

Little did I think, back in 2015 when I was working on the first edition of *Essentials of Nursing Practice*, that over a decade later I would be updating chapters and preparing new material for a fourth edition. Since that first publication, nursing in the UK has faced significant challenges, including the COVID-19 pandemic, severe workforce shortages, pay disputes, unsafe care conditions and escalating pressure on services. It is fair to say that the decade has been hard not only for nurses, but also for those to whom they deliver care.

To focus solely on the challenges, however, would not do UK nursing justice. Despite sustained system pressures, UK nurses continue to be recognised for excellence in care, innovation and transformational, compassionate leadership. This resilience is far from surprising: it reflects the enduring spirit of nursing, which ensures that core values are upheld even when systems struggle.

Every day, nurses across the UK demonstrate extraordinary dedication, compassion and skill. They hold teams together, advocate for those whose voices are quietest and bring dignity and humanity to the moments that matter most. Even when resources are stretched to breaking point, the UK nursing presence continues to change lives for the better. The impact nurses make in the UK is profound, often unseen, but always felt.

To contribute to ongoing excellence in nursing care, I am delighted to share with you the fourth edition of *Essentials of Nursing Practice*, and who knows, maybe in 2036 I will be reflecting on 20 years of a remarkable journey.

Catherine Delves-Yates

^uncorrected proofs^

Acknowledgements

The editors and SAGE would like to thank all the students, patients/service users and nurses who contributed their stories to the book and online resources. The book is much richer for your contribution.

We would also like to thank all the students, lecturers and practitioners who helped to review this book's content, design and online resources to ensure it is as useful as possible.

Patients, service users, carers and families

The stories have been anonymised or first names only used to protect privacy. We wish to thank all of you and give special thanks to the following organisations for working with us to provide some of the voices:

Reviewers

Lisa Jennison, University of Hull

Patience Bamisaye, Anglia Ruskin University

Tamsin Smith, University of Highlands and Islands

Thomas Beary, University of Hertfordshire

Joanne Jones, Bangor University

Anne Ambridge, Kingston University

Lucy Kirkham, Sheffield Hallam University

Mark Broom, University of South Wales

Sera Manning, University of the West of England

Valerie Ness, Glasgow Caledonian University

Lastly, the editors and SAGE would like to extend special thanks to Lucy Kirkham for her role as editor of the online Teaching Guide resource.

^uncorrected proofs^

Introduction

This book has been written for nursing students undertaking a pre-registration degree, no matter what field of nursing you are studying. While the book is primarily aimed at nursing students in the first year of their studies, it presents a solid foundation of relevant material for any nursing programme, such as nursing associate, for example. It will serve as an excellent source of reference material throughout your course and beyond.

This book was developed by a dedicated team of lecturers, practitioners, students, people receiving care and carers to support your study and give you the fullest picture of nursing possible. All have been keen to be involved because they know how important good nursing care is and are aware of the challenges you may face in providing quality care. You may have experienced good care first hand and this may have inspired you to start your own journey to become a nurse. You will probably be aware of news reports highlighting failures in care, and wonder how this can happen. Everyone involved in this book is passionate about providing you with the knowledge, skills and confidence to be the type of nurse who inspires others and creates an environment for practice that prevents the situations you see on the news.

To further help you be the best nurse you can be, we have threaded four fundamental principles throughout the book, which are integral to good nursing care. These are:

Holistic, person-centred care: Nurses don't care for symptoms, they care for people. That is why a deeper understanding of the whole person you are looking after, physically, psychologically, socially and culturally, is key to providing the best nursing care.

Awareness of the needs of all people: No matter what area of nursing you are thinking of specialising in, to provide excellent care you need to be able to respond to the needs of all those you may be working with. The person in your care may be a child or an adult, they may experience mental health problems or have learning disabilities, or have a family or others they care for with problems which may affect their own physical or mental health. The world does not operate in compartments, or distinct pieces on a production line, and nor should you. An ability to care for individuals across the lifespan with varying health needs, and knowing when and how to refer to other professionals, will make you a better nurse and ultimately contribute to a better healthcare system that truly responds to the needs of the people and communities it serves.

Understanding yourself: Being kind to yourself and constantly working on your own development is key to achieving the first principle of holistic person-centred care. Good communication and compassion come when you understand yourself and your own motivations as well as the person/people you are communicating with, and part of that is valuing your own mental and physical health. This is why we involved so many students in developing the book, so that you know you are not alone in worrying about your first placement, or that you do not know how to give a bed-bath, or how you will fit everything in. It is not an easy journey, the challenges of understanding theory, applying it to practice in those first scary moments when you are faced with delivering care for an individual, deepening your knowledge through wider reading and essay assignments, and demonstrating what you have learnt in exams, are big ones. That is why we have developed this book with a structure that recognises these challenges and gives you the

tools you need at each stage of your study to make your learning journey a successful one.

Learning can be fun: It may not feel like it at times, but we hope that you will find, as with most things in life, that the hardest things to learn are often the most rewarding when you finally come to understand them or are able to perform them. We have made the book as interactive as possible, with lots of different forms of learning to keep you excited and interested.

Book structure

The key element of this book is simplicity. The book focuses specifically on helping you to understand the important information you will cover in the first year of your course, and to make it relevant to the care you will deliver. This is done in a range of ways, all of which introduce the essential information you need to understand as a 'skeleton' for you to 'flesh out' with further knowledge. To assist you to do this, you will find sources of further information clearly identified.

In order to assist you to gain the essential foundation knowledge that you as a year one nursing student will need, the book is split into the following themes, each of which forms a part of the book:

Part A – Learning to be a Nurse

Part B – Professional Practice

Part C – Fundamentals of Nursing Care

Part D – Skills for Nursing Care

Part E – Context of Nursing Care

Each of these parts is further divided into chapters, to enable you to develop your knowledge of the important aspects of the theme.

The book presents you with information relating to each of the four fields of nursing practice, learning disability, mental health, child and adult, in an integrated fashion that will assist you to apply it to all of the people you deliver care to. The knowledge and skills you will be focusing on can be thought of as being 'like an onion', because they are made up of many layers. Each of these layers is separate but depends on the others to form the whole. Just like an onion, when you peel back one layer you are faced with another, and then another, and yet another. It is by gaining an understanding of each layer that you add to the depth of your knowledge and increase your ability to be a good nurse. To support you in this development, you will see that the chapters refer you to other relevant chapters or build on material from other chapters, enabling you to recognise how all the different layers fit together.

Requirements for nurse education

In the UK, the Nursing and Midwifery Council (NMC) sets educational standards to ensure that your course of study provides you with high-quality nursing education. These standards outline how nursing students must be educated and the competencies and skills you must be able to demonstrate in order to deliver and manage the current and future needs of all people. The format of this book is designed to assist you to gain the knowledge and skills required to meet the standards set by the NMC.

28

Emergency care

Sara Morgan

This chapter covers

- Goals of first aid
- The ABCDE assessment method
- Basic life support
- Paediatric basic life support
- Managing medical emergencies

Required knowledge

Before reading this chapter, it will be helpful to refresh your anatomical knowledge of the respiratory system and cardiovascular system. The links below will help you.

Respiratory system:

- <https://youtu.be/Yc2yVIAif9g>
- https://youtu.be/0fVoz4V75_E
- <https://youtu.be/Yc2yVIAif9g> .

Cardiovascular system:

- <https://youtu.be/fg8JQmivlzs>

My first experience of witnessing a cardiac arrest was nothing like that portrayed on TV. Although the resuscitation room was busy, what struck me was how organised everyone was. Everyone knew their role and their place in the whole situation. Although I was frightened, I knew the person was receiving the best possible care.

Hannah Taylor, third-year nursing student

Introduction

One of the core principles of nursing is to care for individuals, and with that sometimes comes an expectation from the public that nurses are able to provide first aid if someone is taken ill, both in care settings and the community. The ability to cope and provide care during such stressful situations can seem daunting. To successfully manage such circumstances, knowledge and an ability to remain calm are key.

This chapter will give you the knowledge and principles that are central to managing emergency situations. Using the principles of 'DR's ABCDE', you will be able to structure a systematic assessment of individuals who have been taken ill and initiate treatment up to the point that they are either handed over to definitive care or have recovered. The fundamental principles of the ABCDE assessment will remain with you for your nursing career and you will build on this assessment process throughout your pre-registration education and into your professional life. These principles are relevant for basic first aid up to advanced life support and underpin the Resuscitation Council UK updated guidelines (2025).

As part of the *Standards of Proficiency for Registered Nurses*, the Nursing and Midwifery Council (NMC, 2018b) identifies that at the point of registration all nurses should be able to administer basic physical first aid, including the management of seizures, choking, anaphylaxis and basic life support. A key element of emergency care is first aid management, its principles being relevant to both pre- and intra-hospital care. This is further supported by *The Code* (NMC, 2018a), which identifies the importance of nurses offering help in emergency situations in their practice settings. St John Ambulance (2022) identify the key goals of first aid as:

- to preserve life
- to alleviate suffering
- to prevent further illness and injury
- to promote recovery
- to provide comfort and reassurance.

These principles fit into the Resuscitation Council's ABCDE systematic assessment (Resuscitation Council UK, 2025). Simple first aid skills, such as airway management and cardiopulmonary resuscitation, can be directly life-saving. The effective use of verbal and non-verbal communication skills and providing reassurance can help prevent further suffering. In order to prevent further illness or injury, the primary consideration is the safety of both the injured and the first aider. Once the safety of the casualty is assured, simple first aid skills, such as stemming bleeding, maintaining C spine immobilisation or splinting a fractured limb, can be deployed. In order to promote recovery and ensure the casualty's ongoing safety, the first aider may advise the casualty to attend a local minor injuries unit or arrange transport to secondary care for the more severely injured.

Zideman et al. (2021) describe someone trained in first aid as being able to:

- assess and prioritise the need for first aid management
- use appropriate competencies to provide evidence-based care
- be able to seek additional care and support, depending on the severity of injury and limitations of the first aider.

These are all skills that are fundamental to becoming a registered nurse and are in line with the NMC's *Standards of Proficiency* (NMC, 2018b).

DR's ABCDE

The DR's ABCDE approach to first aid is a simple **mnemonic** used in both first aid and in hospital settings to assess a person with a deteriorating condition. The underlying principles of the

Resuscitation Council UK's (2025) guidelines outline how this method of assessing Danger, Response, Shout for help, Airway, Breathing, Circulation, Disability and Exposure enables first aid to be administered in a targeted and priority-based way. This systematic approach ensures that prioritised care is undertaken. For instance, in the case of severe illness or injury, if protection of airway and support of breathing and circulation are not initiated within a few minutes, many deaths will occur.

Danger

In any emergency situation, whether it is in hospital or in the community, it is vital to be aware of your surroundings and any dangers that may constitute a threat to yourself, others or the injured person. You need to be mindful of how the person became injured and consider how it can impact on your own safety or present potential dangers to yourself or others.

It is common to hear of accounts where rescuers have run into difficulties themselves as a consequence of not adequately assessing a situation. The actions taken will depend on the given situation, the availability of resources and the degree of danger present at the time. Each situation will be unique and will always require measured ongoing assessment to preserve the safety of all involved. Particular attention should be paid to dangers around the casualty, such as traffic, debris, fire, electricity or water. Care should be taken with dangers pertaining to the casualty, especially if you are alone. Be aware of your surroundings and of any sharp objects or needles on or around your casualty. Although it can be tempting to take risks in order to preserve another's life, if you feel the situation is unsafe, call for help and do not approach; you may be putting your own life in danger.

Activity 28.1

Reflection

You're walking through a local park on a quiet afternoon when you notice someone lying on the grass near a bench. Their eyes are closed, and they aren't responding to people walking by. They appear to be in their late 40s, wearing sports clothes and have a half-empty bottle of water beside them.

- What potential dangers or risks are present in this situation for both you and the individual?
- What visual or environmental clues will help you to assess what has happened?
- What actions can you take to safely assess and manage the situation?

ANSWERS AVAILABLE ONLINE: <https://study.sagepub.com/essentialnursing4e>

Response

Unless the casualty is sitting up and talking, you will need to assess their responsiveness. The Resuscitation Council UK (2025) advocate the shout and shake method for adults (children should not be shaken) if they appear unconscious. Shake them and ask 'are you alright?' If they

respond appropriately, then you know they have a **patent airway** and are conscious. If they fail to respond, try again shouting more loudly. Give a command, such as 'open your eyes', and see if they respond. If they still fail to respond, you will need to assess their level of consciousness further. The AVPU scale provides a quick method of assessing consciousness by gauging whether they are Alert, responding to Voice, responding to Painful stimuli or Unresponsive.

A – Alert

Eyes open and the person is aware of what is going on around them.

V – Voice

The person responds to a verbal stimulus.

P – Pain

The person responds to a painful stimulus, squeezing the trapezius muscle or supraorbital pressure.

U – Unresponsive

The person shows no response to pain.

If the person is unresponsive but breathing, their condition will need to be investigated further. How a lack of responsiveness, without any further signs of critical illness, is assessed is discussed in the section on Disability.

Shout for help

If the person requiring first aid appears unconscious and does not respond to your initial commands, it is vital you shout for help, before continuing with your assessment. With any first aid situation it is important to ensure that help is on its way as the person's condition can change quickly. If you send someone off to call the emergency services, ensure that you ask them to return and tell you how long the emergency services anticipate it will take to get to you. If assistance is not forthcoming, continue your assessment, while you continue to shout for help.

Basic life support consists of three primary elements:

- 1 Airway
- 2 Breathing
- 3 Circulation

This method of assessment can be adapted and used in the assessment of anyone with a deteriorating condition both in hospital and in the pre-hospital environment.

Airway

The airway anatomically is a passage between the lips and trachea (Steen, 2010). Obstruction of the airway can very quickly turn into a medical emergency and therefore a patent airway is essential. When someone is unconscious, the tongue becomes flaccid and can fall backwards

obstructing the airway. If someone has lost consciousness, they may also be unable to cough or clear an airway, causing secretions to pool, which in turn obstruct the airway. In simple terms, without a clear airway breathing will be compromised, gas exchange will not take place in the lungs and potentially a hypoxic arrest can ensue. If the person responds verbally, you may presume that they have a patent airway.

Complete obstruction of the airway can very quickly lead to cardiac arrest and needs rapid assessment and intervention. In most instances, simple methods of airway clearance are all that is required and they will be discussed in the following sections. A partially obstructed airway is characterised by noisy breathing; a complete obstruction is where breathing is absent and there is no audible noise. A compromised airway may be caused by:

- inflammation to the upper airway
- fluids pooling within the airway
- central nervous system depression
- inhaled foreign objects
- facial or neck trauma.

Resuscitation Council UK (2025)

In order to assess an airway, you need to look, listen and feel:

- 1 *Look* – Is the person alert, which means that the airway can be considered patent. If the person is not alert, the airway is at risk. First, look for any visible obstructions. Check the mouth for visible obstructions and clear only what you can see. Do not perform a finger sweep unless an object is clearly visible and easily reachable (Resuscitation Council UK, 2025) as it may cause foreign bodies to be pushed deeper into the airway leading to further obstruction.
- 2 *Listen* – Normal breathing is relatively quiet so any noise may be a sign of an obstructed airway. The noises you may hear can be snoring, gurgling, wheezing or **stridor**, which all indicate a potentially obstructed airway.
- 3 *Feel* – The easiest way to assess if air is moving in and out of the airway is to place your cheek close to the person's mouth and feel for air movement. This should be done while undertaking a basic airway manoeuvre to open an individual's airway. One of the most basic methods is 'head tilt chin lift' (see Clinical skill 28.1). If you suspect the person has fallen from a height or sustained a spinal injury, then a 'jaw thrust' airway manoeuvre should be used. It is possible to see the effectiveness of these manoeuvres when someone is unconscious, as the person will either be able to breathe as a result of the intervention or will breathe less noisily.

While both manoeuvres open up the structures of the airway, allowing air to pass through, they do not prevent vomit, blood or secretions pooling. In order to prevent **aspiration**, the unconscious person should be placed in the recovery position (see Clinical skill 28.4), unless in imminent danger of cardiac arrest.

Airway adjuncts

In hospital settings, there is a variety of **airway adjuncts** and devices that can be used to support an airway. One of the most common adjuncts is an oropharyngeal airway device. It can be

used in cardiac arrest to support bag valve mask ventilation or in the unconscious person who may still have **spontaneous breathing** (Lister et al., 2020). Before an oropharyngeal airway is used, it is important to assess whether the person has any obvious facial trauma.

Step-by-step clinical skill 28.1

Head tilt chin lift

☒ **Before you start**

The safety of the first aider is paramount so ensure that the environment is safe for you to approach. If you suspect the person has a spinal injury, move on to a jaw thrust manoeuvre (see Clinical skill 28.2).

☒ **Essential equipment**

If in a care setting, ensure that appropriate personal protective equipment (PPE) is worn.

☒ **Field-specific considerations**

For infants, the head should be in a neutral (natural) position.

☒ **Care setting considerations**

The procedure is the same in any care setting.

Head tilt chin lift guidelines

- 1 **If you are able to do so, put on gloves**
- 2 **Place one hand on the forehead and three fingers under the chin**
- 3 **Apply pressure to the chin and lift the chin as you move the head back**
- 4 **Reassess the airway. Has it relieved the problem? If not, you may require a definitive airway and expert help**

Step-by-step clinical skill 28.2

Jaw thrust

☒ **Before you start**

The safety of the first aider is paramount so ensure that the environment is safe for you to approach.

☒ **Essential equipment**

If in a care setting, ensure that appropriate PPE is worn.

☒ **Field-specific considerations**

There are no field-specific considerations.

☒ **Care setting considerations**

This procedure is the same in any setting.

Jaw thrust guidelines

This is a more complex move to perform. It should be the manoeuvre of choice used in suspected spinal injuries.

- 1 **Place your fingers under the angle of the jaw**
- 2 **Place thumbs on the mandible**
- 3 **Lift the jaw vertically to move the tongue off the back of the throat**
- 4 **Reassess the airway**

Step-by-step clinical skill 28.3

Using an oropharyngeal airway

☒ **Before you start**

Assess the person for any signs of facial trauma.

☒ **Essential equipment**

Appropriate PPE.

Oropharyngeal airway.

☒ **Field-specific considerations**

In children under 8 years of age, the airway should be inserted concave side down using a tongue depressor.

☒ **Care-setting considerations**

This procedure is the same in any care setting.

Oropharyngeal airway guidelines

- 1 **Measure the airway from the angle of the jaw to the corner of the mouth**
- 2 **Insert the airway upside down (concave side up) and position to the junction of the hard and soft palate**
- 3 **Rotate the airway 180 degrees, so the airway lies in the oropharynx (Resuscitation Council UK, 2025)**

As previously stated, someone who has spontaneous breathing but who is either unconscious or has a decreased consciousness level is at risk of aspiration from an impaired cough. The recovery position (see Clinical skill 28.4) ensures that they are nursed on their side, allowing for fluids to drain from their mouth (Hatchett, 2017). While in the recovery position they should continue to receive close monitoring. Pay particular attention to Airway, Breathing and Circulation. Also remember to maintain good pressure area care to prevent skin breakdown.

Step-by-step clinical skill 28.4

Recovery position

✓ Before you start

The safety of the first aider is paramount so ensure that the environment is safe for you to approach the person.

Ensure that you maintain principles of good manual handling.

✓ Essential equipment

Appropriate PPE.

✓ Field-specific considerations

If the person is known to have learning difficulties or cognitive impairment, it may not be possible to ascertain their level of understanding. If the person is not known to the first aider, a relative or carer may be able to give more information.

✓ Care-setting considerations

This procedure can be undertaken in any care setting.

Recovery position guidelines

- 1 Place the arm closest to you at a right angle
- 2 Place the arm furthest away from you across the person's chest
- 3 Bend the leg furthest away from you at 90 degrees
- 4 Use the bent knee to pull the person towards you
- 5 Adjust the upper leg so the hip and knee are at right angles
- 6 Perform a head tilt chin lift to protect the airway

Breathing

Once a patent airway has been secured, the next priority is to assess the quality of breathing. Normal breathing should be relatively quiet and effortless, with the person able to talk in full sentences. When assessing breathing, the look, listen, feel approach can be used again. Look for the rise and fall of the chest, listen for breath sounds and feel for air movement on your cheek. If they are breathing, the following assessment should be made of their breaths for one minute:

- Rate
- Rhythm
- Depth.

The normal respiratory rate is 12–20 breaths per minute. A **bradypnea** of less than 12 breaths can potentially be attributed to opioid toxicity or an underlying head injury (Smith and Bowen, 2017). A **tachypnoea** of more than 20 breaths per minute can be attributed to underlying respiratory disease, acute illness or states of anxiety.

It is also important to evaluate the depth of breathing. People who are metabolically acidotic may present with a rapid deep respiration rate (Jevon et al., 2012). For example, anyone with

diabetic ketoacidosis will have a high concentration of ketone bodies, making circulating body fluids acidotic. Conversely, shallow respirations may be a result of opioid toxicity. Chest movement should be symmetrical. Any asymmetry of chest movement should be noted at this stage because it may indicate underlying pathology, such as a **pneumothorax**, rib fracture or pleural effusion (large), all of which can occur from disease or trauma. A pneumothorax is known colloquially as a 'collapsed lung' and occurs when air leaks into the pleural cavity (Asthma + Lung UK, 2024). The trachea should also be inspected, ensuring it is in the midline. When displaced, the trachea will be moved in the direction of less pressure (Ball et al., 2019), thus away from a pneumothorax and towards a consolidation.

The chest shape should also be observed as it can indicate an underlying pathology. Some deformities may be congenital, such as pectus excavatum, or acquired, such as pectus carinatum. Hyper expansion or a barrel chest is associated with chronic disease such as asthma or chronic obstructive pulmonary disease (COPD) (Innes et al., 2018). At this point, the use of any accessory muscles should be noted. The use of the shoulder, neck or intercostal muscles indicates increased effort of breathing, which is often evident in people in respiratory distress (Bickley and Szilagyi, 2021).

In an emergency situation outside a clinical setting, you may be limited in how you can support breathing. If safe to do so, sitting the person in an upright position will help. Loosen any tight clothing on the upper thorax that may be constricting the chest and making breathing more difficult. If the person has a known respiratory condition such as asthma and has their medication with them, you may assist them to take it.

In a clinical setting you should have access to pulse oximetry, which measures how much of a substance, usually oxygen, is bound to haemoglobin. Recognised as the fifth vital sign, SpO₂ offers a real-time guide to oxygenation at the tissue level (Chan et al., 2013) (see Chapter 24 for further details). The National Early Warning Score 2 (NEWS2) (Royal College of Physicians (RCP), 2017) stipulates that oxygen saturations in a healthy individual should be above 96%. SpO₂ may be lower in a person who has a known respiratory condition, such as COPD. As the oxygen level decreases, supplementary oxygen should be administered by a trained healthcare professional. In this situation, in hospital settings, the Resuscitation Council UK (2025) recommend 15 L of oxygen via a non-rebreather mask. If the person has type 2 respiratory failure, oxygen saturations of between 88% and 92% should be aimed for, to prevent their breathing being depressed. Type 2 respiratory failure occurs when there is both a lack of oxygen and a high level of carbon dioxide. Elevated carbon dioxide levels are a result of the respiratory system being unable to adequately expire the gas in conditions such as COPD. If the individual is not breathing or has **agonal breathing**, you should commence chest compressions immediately; cardiopulmonary resuscitation will be discussed later in this chapter.

Circulation

Assessing and palpating a pulse is a skill that can take time to learn, but it is a skill that can tell us a lot about a person's condition. The reason for assessing the pulse is to determine heart rate and to assess rate, rhythm and character. The radial artery is frequently used for initial assessment as it is at the wrist and tends to be easily accessible. For people in a more severe or critical condition, a more central pulse, such as the carotid, should be felt. Many factors affect heart rate, including anxiety, pain, fever and medications, and they should be considered when assessing the pulse. See below for normal resting heart rate by age.

Normal heart rate at rest by age:

- Infant – 110–170
- Child 1–2 – 100–160
- Child 2–5 – 80–150
- Child 5–12 – 65–110
- Adolescent to adult – 60–110.

Source: Hewitt (2018)

When palpating the radial pulse, you should lightly compress the radial artery and count the number of beats in one minute. When assessing the pulse, the character of the pulse rate should also be assessed, as it reflects the volume of blood, cardiac output and elasticity of the arterial wall (Hensler, 2020; see the list below).

Description of pulse volume:

Grade 3 = full bounding

Grade 2 = normal

Grade 1 = weak or thready

Grade 0 = absent or non-palpable.

Source: Hensler (2020)

A pulse of less than 60 bpm is classed as bradycardia (Jones et al., 2010). It may be related to medication such as beta blockers, but athletic people also have low pulse rates. Pulse rate also naturally drops during sleep. A rate of less than 50 bpm (Resuscitation Council UK, 2025) can lead to a significant depression in cardiac output. Tachycardia is defined as a heart rate above 100 bpm (Jones et al., 2010). It may be as a result of pain, anxiety or medication. Tachycardia may also be a compensatory mechanism to a reduced cardiac output and should be monitored closely in any emergency situation. A compensatory mechanism helps the body to maintain homeostasis – in this instance, an increased heart rate will help to maintain cardiac output and oxygen delivery to tissues.

If you are within a hospital setting, an accurate blood pressure reading is a key element of a circulatory assessment. Blood pressure results from a combination of blood volume, cardiac output and peripheral resistance (Park et al., 2022). Again, many factors affect blood pressure values, including physiological and genetic causes. The normal blood pressure range in adults is between 90/60 and 140/90 (Nicol et al., 2012). Hypotension is classed as a blood pressure below 90 mmHg systolic, which can indicate shock and is often a late sign of deterioration, signifying a failure of the body's compensatory mechanisms (Smith and Bowen, 2017). At this point, it should be noted that it is only the systolic blood pressure reading that influences a person's NEWS2 score, as it is a more important indicator of deterioration and impending collapse (RCP, 2012). See Chapter 24 for further information on blood pressure.

External haemorrhage

One of the most common causes of shock is bleeding and blood loss. It is therefore imperative that you know how to manage external haemorrhage. External bleeding may occur from all manner of things – from DIY accidents, direct trauma or deliberate self-harm.

Bleeding that is pulsating is likely to be arterial and can quickly lead to catastrophic haemorrhage. In this instance, a quick wound assessment is a priority and the volume of blood loss should also be considered. Significant arterial blood loss (where blood is spurting) is life-threatening and should be controlled as a priority – if necessary before you undertake an ABCDE assessment. In this instance, a C-ABCDE assessment should be implemented (C standing for catastrophic haemorrhage, which can cause death in minutes (Geeky Medics, 2022).

The first step is to apply direct pressure to the wound, but before doing this you need to ensure that there are no obvious foreign bodies that can cause further damage when you do it. While checking for foreign bodies also assess the colour of the blood – bright red blood is usually arterial; venous and capillary blood will be much darker. Applying direct pressure to the wound and limb elevation can assist in halting or controlling external bleeding (Wilcox, 2020). Ideally, you will have a sterile absorbent dressing pad to press firmly over the source of bleeding. If you are in the community and lack access to sterile equipment, any clean absorbent material will suffice. If there is a foreign body embedded in the wound, pressure should be applied to the wound edges. Pushing over the foreign body may push it deeper into the wound causing further damage to underlying structures. Do not be tempted to remove the object as this can cause the wound to **exsanguinate**. For your own safety, ensure that **universal precautions** are taken. If you have nothing available, you may need to talk the person through the process of controlling the bleeding themselves. This obviously relies on the individual being conscious and able to follow commands. Initially, start with light pressure and increase the pressure until the bleeding is controlled. Apply a bandage so that it covers the wound and apply pressure directly over the injury site. If bleeding soaks through the dressing, apply another (without removing the first) and increase the pressure. If the bleeding stops, leave the bandages in position until the person is in a place of definitive care, such as a minor injuries unit or an Accident and Emergency department.

Basic life support

The Resuscitation Council UK describes something called ‘the chain of survival’. It is a fundamentally important aspect of basic life support. The links in the chain of survival are:

- early recognition and call for help
- early cardiopulmonary resuscitation
- early defibrillation
- post-resuscitation care.

Each link in the chain increases the person’s chance of surviving a cardiac arrest and prevents further deterioration.

It is vital to identify a person’s deterioration quickly to prevent cardiorespiratory arrest. However, if they deteriorate to the point of cardiac arrest, it is vital that it is recognised quickly and early and CPR is started immediately. This is true whether in the community or in a hospital setting. Help should always be summoned in such situations and if the person does not have a pulse, early defibrillation within three minutes is imperative (Resuscitation Council UK, 2025).

For a person who is not breathing or only making occasional agonal breaths, chest compressions should be started as soon as safely possible. Effective compressions maximise blood flow

and oxygen to vital organs such as the heart and to the brain. If an **automated external defibrillator (AED)** is available, it should also be brought to the situation and used. In the community, places such as shopping centres, leisure centres, schools and community centres have AEDs available for the public to use. We will consider AEDs in more detail in the next section. Compressions are undertaken by first interlocking your fingers and placing the heel of your hand in the centre of the chest. Position your shoulders vertically above the person's chest and compress 5–6 cm (Resuscitation Council UK, 2025); after each compression release the pressure so the chest reinflates. This process should be repeated at a rate of 100–120 times per minute (see Figure 28.1a and b for correct positioning).

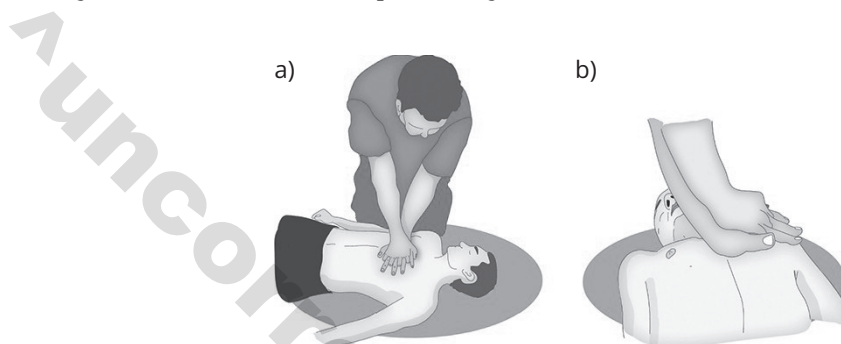


Figure 28.1a and b Correct hand positioning for cardiac compressions

After 30 compressions, if you have been trained to do so, you should give two rescue breaths. To do this, first open the airway using the head tilt chin lift manoeuvre (see Clinical skill 28.1), then administer two rescue breaths. Pinch the soft part of the nose, take a normal breath and place your lips around the casualty's lips forming a tight seal. Breathe steadily into their mouth watching their chest rise for around one second, wait for the chest to fall before delivering the second breath. Immediately after the second breath has been delivered you should resume your chest compressions at a rate of 30 compressions to two rescue breaths. If you are unable to give rescue breaths, you should deliver chest compression only CPR at a rate of 100–120 compressions per minute. Resuscitation should only be stopped if the person shows signs of life, or you become exhausted.

Automated external defibrillator

Defibrillation is when an electrical shock is applied to the chest wall; this transfers through to the myocardium and may return a person's heart rhythm to normal. It is therefore vital that when it is indicated, the casualty is defibrillated rapidly. Early defibrillation should occur as soon as an AED becomes available, with minimal interruptions to chest compressions. The Resuscitation Council UK (2025) highlights that defibrillation should take place within three minutes. Using an AED requires minimal training and once turned on it tells you, by an internal voice, what you need to do. There are numerous examples in local communities of the general public using AEDs and saving lives. Nurses and nursing students are trained to use AEDs as part of immediate life support courses.

My first experience of a cardiac arrest as a nursing student was on an A&E placement, I remember the scary moment I realised my patient was no longer breathing. I shouted for help. Within seconds staff from all over the department appeared and very quickly the scene was under control with roles and tasks being assigned. Being part of such an experienced team meant I was always next to someone who could reassure and guide me through this intense experience and prepare me ready for my next. Following the incident, my practice supervisor took me to one side and talked me through what had happened and what I had witnessed and the decisions that the cardiac arrest team had made. I was frightened of not providing good-quality CPR but my practice supervisor was there to reassure me.

Sam Taylor, NQN

Paediatric basic life support

Fortunately, cardiac arrest in children is extremely rare. It is undoubtedly one of the most challenging situations that even experienced nurses will face, but it is important for any healthcare student or professional to be familiar with the skill needed to perform paediatric life support.

The majority of paediatric cardiac arrests are secondary to other causes, with respiratory insufficiency being the most frequent (Resuscitation Council UK, 2025). The same DR's ABCDE sequence should be followed. Essentially, paediatric life support mimics that of adults but with some modifications.

Step-by-step clinical skill 28.5

Paediatric basic life support

☒ **What is normal?**

Only ever perform this skill on a collapsed, unresponsive child or infant with no signs of life.

☒ **Before you start**

Remember to assess the safety of the environment before you start.

☒ **Care-setting considerations**

This can be undertaken in any care setting.

It is also important to remember that some form of resuscitation is better than doing nothing.

Paediatric basic life support guidelines

- 1 **Check if the child is responsive. In infants, tickling the feet usually elicits a response. Do not shake children**
- 2 **If there is no response, shout for help**
- 3 **To open a child's airway, use the 'head tilt chin lift' manoeuvre. In infants, keep the head in a neutral position. As children's airways are delicate, be careful not to**

(Continued)

push on the soft tissue under the chin as this may block the airway (Resuscitation Council UK, 2025)

- 4 **If there are no visible chest movements, administer five rescue breaths. In babies and infants, you can make a seal with your mouth around both their lips and nose in order to deliver the rescue breaths**
- 5 **If there are no signs of life, start chest compressions. In children under 1 year old, the tips of two fingers should be used in the middle of the chest. In children over 1 year, use the heel of one hand placed one finger width above the xiphisternum. Compressions should be at a ratio of 15 compressions to two rescue breaths**

If you are a lone rescuer and no help is available, you should undertake one minute of resuscitation before calling for help. With younger children it may be possible to carry the child while gaining help.

If a defibrillator is available, although a primary cardiac arrest is rare, you should still attach it to the child.

It is fundamental that everyone has an understanding of paediatric basic life support. It saves lives.

Amanda Dickenson, Paeds ENP

Case study 28.1

Maya

Maya is 11 months old and has just started crawling. While her mum was preparing lunch, Maya was playing near the coffee table where some peanuts had been accidentally dropped. Moments later, Maya begins to cough and gasp. Her mum rushes to you in a panic. Maya is still coughing intermittently, but her face appears red and there are signs of distress.

- How would you manage this situation?
- What would be your immediate priorities?

ANSWERS AVAILABLE ONLINE: <https://study.sagepub.com/essentialnursing4e>

Disability

Disability assesses any deficit in neurological functioning that might be present. The most effective way to do this in an emergency situation is, as we have already discussed, by applying the AVPU scale. However, if there are no other signs of critical illness, the cause of the lack of response needs to be investigated further.

The Glasgow Coma Scale (GCS) is a **neuromonitoring** tool you may see used in hospital settings. It measures the depth and duration of altered consciousness (Waterhouse, 2008), and has been used worldwide for over 50 years to assess an individual's level of consciousness (Brennan et al., 2024). The GCS enables the nurse to observe three aspects of behaviour:

- eye opening
- motor response
- verbal response.

Each aspect combined generates a score out of 15. A fully conscious person who is oriented to time and place will score 15/15, whereas an unconscious person will score 3/15. The graph corresponding to the score helps to identify trends in improvement or deterioration in their condition. The GCS serves as an early indication of potential intercranial complications, prior to neurological deterioration occurring (Brennan et al., 2024).

Other tests, such as FAST, can also be assessed: does the person have any *facial drooping*? Can they lift their *arms*? And do they have any *slurring of speech*? If any of the three aspects are present, you should have a high suspicion of a cerebrovascular accident (CVA) and should call for help.

The Resuscitation Council UK (2025) also advocates checking the individual's blood glucose. Hypoglycaemia (low blood sugar) can be a contributing factor to unconsciousness. If the person is in hospital, it is also worth reviewing their medication charts to see if there are any drugs that may have caused a drop in consciousness level.

Exposure

In order to fully assess the person, it will be necessary to fully expose the person (Resuscitation Council UK, 2025) to look for other injuries. You will be looking for wounds, rashes, bruising or anything else that may be causing the person's deterioration. The individual's dignity must be maintained during this process, which may be challenging out of hospital. It may not be appropriate to remove the person's clothing, but instead visually check the body for any visible signs of injury, remembering that skin damage such as rashes and bruising can look different depending on a person's skin colour. In hospital settings, the person's clothing should be removed in order to look for signs of injuries.

Case study 28.2

Mary

You are on placement in a Memory Clinic. Mary, a regular patient at the Memory Clinic, attends her monthly appointment accompanied by her husband and primary carer, David. Mary has a diagnosis of mild dementia and is well known to the clinic staff. On this occasion, you are asked by your practice supervisor to carry out a routine assessment of Mary.

As you begin your interaction, you notice that David appears unwell – he is pale, clammy and visibly fatigued. Concerned, you offer him a glass of water. When you return with the drink, you find David collapsed in his chair, unresponsive to verbal stimuli.

- How will you manage this situation?
- What will be your priorities?
- What (if any) additional care will you need to plan for Mary?
- What implications will David's condition have on Mary's continuing care at home?

ANSWERS AVAILABLE ONLINE: <https://study.sagepub.com/essentialnursing4e>

Medical emergencies

While DR's ABCDE gives us a fundamental approach to emergency care, there are other situations where you need to act quickly and effectively.

Choking

Choking is a cause of accidental death, but with rapid and effective actions it can often be effectively treated. Choking is often a result of a food bolus and in children particularly, inhaled objects. It can cause either partial or complete airway obstruction. The hypoxia resulting from an airway obstruction can lead to irreversible brain damage or even death in 4–6 minutes (Verma, 2011). If the correct first aid measures are instigated quickly, in many cases the obstruction can be dislodged.

In a situation where an adult or child is choking, the basic steps of DR's ABCDE, already discussed in this chapter, should be followed. It is still imperative that the environment is safe and that you summon help quickly. It may seem obvious but if you find a person in distress and you think they may be choking, ask them: 'Are you choking?' If they are able to speak and cough, they are likely to have a partial airway obstruction (Perkins et al., 2021); if they cannot speak and are unable to cough, their airway is likely to be fully obstructed.

In the case of partial airway obstruction, coughing should be encouraged (Simpson, 2016). Coughing will create a high pressure in the patient's airway and may be enough to dislodge the obstruction (Perkins et al., 2021). If the object is not dislodged, you should follow the steps in Clinical skill 28.6.

Step-by-step clinical skill 28.6

Dislodging an obstruction to the airway

☒ **What is normal?**

The distressed person may or may not be coughing.

☒ **Before you start**

Perform a risk assessment and ensure the environment is safe before you approach the person.

☒ **Field-specific considerations**

In infants, remember to use back slaps and chest thrusts.

☒ **Care-setting considerations**

The procedure can be managed in any care setting.

Dislodging an obstruction to the airway guidelines

- 1 **If the person is conscious administer five back blows; if this does not clear the obstruction you must then deliver up to five abdominal thrusts (not for children or infants)**

These steps should be carried out while the person is conscious and until the obstruction is dislodged.

- 2 **In order to perform abdominal thrusts, you should stand behind the adult, place your arms around them, put a clenched fist of one hand in the centre of the chest, grasp with the other hand and push upwards (Resuscitation Council UK, 2025)**
- 3 **If the person is unconscious, either call 999 or (if in hospital) the cardiac arrest team immediately**

Chest thrusts cause greater airway pressures than abdominal thrusts; in the unconscious person, CPR mimics this movement and should be commenced immediately (NHS, 2023).

In children

- 1 **If the child has an effective cough, encourage them to clear the obstruction; if the cough is ineffective, call 999 or (if in hospital) the cardiac arrest team immediately**
- 2 **In small children and infants, place the child in a head down position, supporting the head, and deliver five back blows**
- 3 **In older children, follow the same actions as for adults**
- 4 **For infants under 1 year, you will need to deliver chest thrusts, one finger breadth above the xiphisternum, at a rate of 20 chest thrusts per minute**

(Verma, 2011)

Seizures

Epilepsy affects 1% of the UK population and approximately 600,000 people are living with the condition (Epilepsy Society, 2024). It is not only epilepsy that is responsible for generalised seizures – other causes can be hypoglycaemia, pregnancy or a CVA. A seizure has been defined as a sudden surge of electrical activity in the brain, affecting how a person appears or acts for a short time (Epilepsy Foundation, 2014). There are many forms of seizures, ranging from absence, where a person has a short period of absence of understanding, through to loss of muscle control leading to forceful uncoordinated muscle contractures. Individuals will often experience incontinence, tongue biting and may sustain other injuries during seizures. There may also be issues maintaining the person's airway and breathing. In prolonged seizures, it can lead to hypoxic brain injuries.

The main priorities when treating a person having a seizure is to maintain their airway and safety. Maintaining an airway in first-aid situations can be challenging as you may have no equipment available to you. Never attempt to restrain the person and do not place anything in their mouth. People will often bite their tongue during a seizure and the ensuing bleeding may cause issues for the individual maintaining their airway. Once the acute phase is over, you should attempt to place the individual in the recovery position (see Clinical skill 28.4). If the person is known to have epilepsy, you should time the seizure; many are self-limiting and will require no medical intervention. However, if the person has never had a seizure before, or the seizure lasts more than 5 minutes, or the person has another seizure without fully recovering, they should be transferred to emergency care (NICE, 2024b).

Case study 28.3

Janine

Janine is 23 years old and has a known diagnosis of epilepsy. She is attending her routine outpatient clinic appointment. While she is in the process of checking in, she suddenly lets out a loud scream, collapses and begins convulsing. On your initial assessment, you notice she has a blue tinge to her lips.

- What are your immediate priorities in this situation?
- How can you ensure Janine's safety during this event?
- What ongoing care may be necessary to help stop Janine's seizure?

ANSWERS AVAILABLE ONLINE: <https://study.sagepub.com/essentialnursing4e>

Head injury

A head injury is a not uncommon injury requiring first aid. Common causes of head injuries are falls, assaults, road traffic accidents and sporting injuries. Each year 600,000 people attend Emergency Departments in England and Wales with head injuries (Rajesh et al., 2023). Many injuries will be superficial and may require some treatment for the wounds sustained. However, over recent years the role of concussion in sport has had much publicity, leading to many governing bodies involved in contact sports issuing guidelines on the management of concussion.

Concussion is a traumatic brain injury caused by a diffuse injury to the head, disturbing the brain's function. Some of the common signs of concussion are loss of consciousness (although this occurs in less than 10% of individuals), headache, dizziness, memory loss and/or vomiting (Welsh Rugby Union (WRU), 2024). These signs and symptoms can occur at any time following the head injury, but typically within the first 24–48 hours. Symptoms typically resolve within 7–10 days and around a third resolve within 1–2 days (Rugby Football Union (RFU), 2023).

The signs of concussion are:

- a dazed or vacant look
- unsteadiness on feet post-injury
- loss of consciousness (LOC)
- confusion
- disorientation to time, place and person
- nausea or vomiting
- irritability
- poor concentration
- fatigue.

(NICE, 2023)

Anybody requiring first aid for a head injury with symptoms of amnesia, persistent headache post-injury, loss of consciousness, vomiting, history of anticoagulation therapy, drug or alcohol intoxication, individuals over 65, or a person presenting with irritable or altered behaviour

should be advised to seek further medical advice. The majority of cases falling outside these conditions can be managed safely at home, and some simple first-aid measures will improve symptoms:

- Hold an icepack to the injured area for short periods to reduce swelling
- Rest
- Take simple analgesia available from the pharmacy.

Even people with mild head injuries should be advised not to be left unattended for the first 24 hours post-injury (NICE, 2023). Most sports governing bodies will have a return to play policy and this should be adhered to before resuming any sporting activity.

Activity 28.2

Critical thinking

Take some time to thoroughly review the DR's ABCDE assessment. Which steps are you confident in performing? In which areas do you feel you need to strengthen your knowledge, and what actions can you take to improve?

ANSWERS AVAILABLE ONLINE: <https://study.sagepub.com/essentialnursing4e>

Conclusion

DR's ABCDE is the mainstay of first aid management, and this system of assessment will enable you to develop skills in delivering first aid treatment. The assessment is used in the hospital setting to assess deteriorating people and should therefore become a familiar tool. The approach offers you a coping strategy in what can be a very stressful environment. It is important to remember that in any first aid situation never place yourself in danger, utilise the DR's ABCDE assessment strategy, call for help early on and arrange for transport to definitive care, if required.

Chapter summary

- The primary goal of first aid is to preserve life, limit deterioration and promote recovery.
- Ensure the environment is safe for you to approach.
- After checking the person's response, shout for help.
- DR's ABCDE is a useful tool to use in emergency situations.
- For a person in cardiac arrest, good-quality CPR and early defibrillation offer the best chance of survival.

Critical reflection

Holistic care

Reflect on a situation where you provided emergency care to an individual. What steps did you take to ensure that the care you provided addressed all aspects of their needs?

Go further

Books

St John Ambulance, St Andrew's First Aid, & British Red Cross. (2022). *First aid manual* (11th ed.). DK. This manual is authorised by the major first aid providers in the UK and gives lay individuals an understanding of the principles of first aid management.

Whittington, R., & Begley, A. (2021). *Emergency nursing at a glance* (2nd ed.). Wiley-Blackwell. This book is a clear and accessible introduction to emergency nursing that simplifies complex concepts with excellent graphics. It will help you to be confident in ABCDE assessment and in recognising deterioration.

Journal articles

Hesami, F., Yousefi, Z., Mottahedi, M., & Bagheri, H. (2025). Exploring nursing students' emotional experiences of patient cardiac arrest in the operating room: A descriptive phenomenological study. *BMC Medical Education*, 25(1), 864. <https://doi.org/10.1186/s12909-025-07475-2>. This study explores how nursing students emotionally experience witnessing a cardiac arrest in the operating room in order to improve clinical education and psychological support for students.

Perkins, G. D., Graesner, J. T., Semeraro, F., et al. (2021). European Resuscitation Council Guidelines 2021: Executive summary. *Resuscitation*, 161, 1–60. <https://doi.org/10.1016/j.resuscitation.2021.02.003>. This article provides an explanation of the contents of the European Resuscitation Guidelines.

Weblinks

www.resus.org.uk/library/abcde-approach – The ABCDE Approach | Resuscitation Council UK. This website will take you through the DR's ABCDE assessment in more detail.

www.glasgowcomascale.org/ – Glasgow Coma Scale. This resource will give you evidence-based information for undertaking a neurological assessment.

www.redcrossfirstaidtraining.co.uk – offers first aid advice. It is part of the British Red Cross.

www.sja.org.uk/get-advice/ – St John Ambulance is a UK-based charity which offers first aid advice and training.

www.nice.org.uk/guidance/cg50 – Overview | Acutely ill adults in hospital: recognising and responding to deterioration | Guidance | NICE. This guidance from the National Institute of Clinical Excellence is an evidenced-based resource, giving guidance on the minimum standards of care that should be used in clinical settings when caring for an acutely ill person.

www.epilepsy.com/learn/epilepsy-101/what-seizure – this web resource will help you to understand the care and management of a person having an epileptic seizure.

Glossary

Agonal breathing A shallow breathing or gasping associated with cardiac arrest.

Airway adjuncts Equipment such as an oropharyngeal airway that helps maintain an open airway.

Aspiration When food, drink or stomach contents are accidentally breathed into the lungs.

Automated external defibrillator A portable device that sends an electrical shock through a person's heart when in cardiac arrest.

Bradypnea A respiration rate of less than 12.

Exsanguinate To lose large volumes of blood.

Mnemonic A word, phrase, rhyme or pattern that makes something easier to remember.

Neuromonitoring To monitor the neurological system.

Patent airway A clear airway free from obstructions.

Pneumothorax A collapsed lung.

Spontaneous breathing Natural breathing.

Stridor A high-pitched wheeze that is a sign of an upper airway obstruction.

Tachypnoea A respiration rate of more than 20.

Universal precautions Items including gloves and aprons to protect individuals from bodily fluids.