Assessment of vital signs

Health & Medicine, Nursing

Assessment of Vital Signs Number I, as a staff nurse on a medical surgical unit at the Hospital, have been assigned to admit Ms. Howard, a 78 year old obese Caucasian female into my unit. Ms. Howard, who is being admitted for sepsis and hypertension, appears to be short of breath when I meet her in the assessment room. My purpose is to complete a full health history and conduct physical examination. I begin by taking her vital signs. To measure her vital signs I use a pen and a paper (for noting the measurements), digital thermometer (for temperature assessment), a timer (for pulse) and an appropriately sized (she is obese) blood pressure cuff and stethoscope (for measuring her blood pressure) (MacGregor & Kaplan, 2010).

After a brief interview, the patient reveals the cause of her short breath and explains she deliberately avoided the escalator on her way to the examination room and took a walk up the stairs (following the doctors' advice to exercise some more). I allow her approximately 15 minutes to calm down then provide her with a gown and leave the room for her to change after instructing her to remove all her dressing except the briefs and put on the gown so that the opening is on the rear. The examination room is quiet, warm and well lit. All the measurements are taken with the patient seated down (McPhee & Papadakis, 2011).

Since the patient has been allowed over 10 minutes to calm down and has not eaten or drank anything hot or cold, smoked, chewed gum in the last 10 minutes, I proceed to assess her temperature. I place a digital thermometer under her tongue to take an oral temperature and wait for it to beep before withdrawing it. I then note the patient's temperature as indicated by the thermometer, part of the body from where it is taken and the time it was

taken (McPhee, Papadakis, & Rabow, 2012).

To find the patient’s pulse, I use my fingers (without the thumb) to press against the bony part of the patient’s wrist. Pressing the artery between the fingers and the wrist bone assists me to feel the pulse. Care is taken not to press too hard. Upon finding a pulse, I use a timer to count the number of beats that occur in a minute (since the pulse appears irregular). I then write down the heart rate, the irregularities observed and the time the pulse is taken (Crouch & Meurier, 2011).

I then go on to assess the respiration without informing my patient since her knowledge of an on-going respiration assessment may inevitably cause her to alter her respiration and hence lead to erroneous conclusions. I count the number of inhalations that occur in 15 seconds then multiply this by 4 to get the respiration rate. The patient’s respiration is labored and raspy. I write down the obtained respiration rate along with the abnormalities recorded and the time the assessment is done (Roberts & Hedges, 2013).

For the blood pressure, I position the patient’s arm so that the elbow is about even with the heart and slightly bent then wrap the selected blood pressure cuff around Ms. Howard’s upper arm. I ensure the cuff is snub but not too tight and high enough that it will sit on the crook of the elbow. I use the stethoscope on the arm to listen for a pulse, then close the valve and use the bulb to inflate the cuff. I listen for the pulse to disappear. I continue inflating until the gauge reads 30 millimeters of mercury (mmHg) higher than it did when the pulse disappeared. I then open the valve just enough to let the air out slowly (no faster than 5mmHg/second). I listen for the pulse to return,

and upon hearing the pulse again, I note the reading as the systolic pressure.

I continue deflating the cuff while listening to the pulse then note the reading when the pulse disappears again. This is the diastolic pressure. I then write down the blood pressure obtained (systolic pressure, then forward slash, then diastolic pressure). I repeat the same procedure for the other arm then record each blood pressure reading, the arm used to take the reading and the time I took the reading (McPhee & Papadakis, 2011).

References

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