#### PROSECAL ASSESSMENT EXAMINATION STUDY GUIDE

#### Vital Signs

Vital signs, generally described as the measurement of temperature, pulse, respirations and blood pressure, give an immediate picture of a person's current state of health and well being. Normal and stinormal ranges with management pushelines follow for children and adults.

#### Equipment Needed

- 1. Shethospope
- 2. Blood Pressure Cuff
- 3. Watch Displaying Seconds.
- 4. Thermometer

#### General Considerations

- The patient should not have had alcohol, tobacco, caffeine, or performed vigorous exercise within 30 minutes of the exam.
- Ideally the patient should be sitting with feet on the floor and their back supported. The examination room should be quiet and the patient comfortable.
- History of hypertension, slow or rapid pulse, and current medications should always be obtained.

#### A. Temperature

- Temperature can be measured is several different ways:
  - a) Orall with a glass, paper, or electronic thermometer (normal 98.6F/37C)
  - b) Axillary with a glass or electronic thermometer (normal 97.6F/36.3C).
  - c) Rectal or "core" with a glass or electronic thermometer (normal 99.6F/37,PG).
  - Aural (the ear) with an electronic thermometer (normal 99:6F/37.7C).
- 2. Of these, asiliary is the least and rectal is the most accurate.
- Use back of hand idorsal aspect) to assess skin temperature.

#### B. Respiration

- Best done immediately after taking the patient's pulse. Do not announce that you are measuring resolutions.
- Without letting go of the patients wrist begin to observe the patient's breathing. Is it normal or labored?
- Count breaths for 15 seconds and multiply this number by 4 to yield the breaths per minute.
- In adults, normal resting respiratory rate is between 14-20 treaths/minute.
- Rapid respiration is called tachsones.

#### C. Pulse - see also Cardiovascular Exam.

- Sit or stand facing your patient.
- Grasp the patient's wrist with your free (non-watch bearing) hand (patient's right with your right or patient's left with your left). There is no reason for the patient's arm to be in an awkward position, just imagine you're shaking hands.
- Compress the radial artery with your index and middle fingers.
- Count the pulse for 15 seconds and multiply by 4.
- Always count for a full minute if the pulse is irregular.
- Record the rate and mythin.

Note whether the pulse is regular or irregular:

Regular - evenly spaced beets, may vary slightly with respiration

Regularly Irregular - regular pattern overall with "skipped" beats.

Irregularly Irregular - chaotic, no real pattern, very difficult to measure rate accurately

# Nln Health Physical Assessment Study Guide

**SA Adler** 

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