#### 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.
- 4. 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

**Didier Musso** 

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# **Table of Contents Nln Health Physical Assessment Study Guide**

- 1. Understanding the eBook Nln Health Physical Assessment Study Guide
  - o The Rise of Digital Reading Nln Health Physical Assessment Study Guide
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Nln Health Physical Assessment Study Guide
  - Exploring Different Genres
  - o Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Nln Health Physical Assessment Study Guide
  - User-Friendly Interface
- 4. Exploring eBook Recommendations from Nln Health Physical Assessment Study Guide
  - Personalized Recommendations
  - Nln Health Physical Assessment Study Guide User Reviews and Ratings

- Nln Health Physical Assessment Study Guide and Bestseller Lists
- 5. Accessing Nln Health Physical Assessment Study Guide Free and Paid eBooks
  - Nln Health Physical Assessment Study Guide Public Domain eBooks
  - Nln Health Physical Assessment Study Guide eBook Subscription Services
  - Nln Health Physical Assessment Study Guide Budget-Friendly Options
- 6. Navigating Nln Health Physical Assessment Study Guide eBook Formats
  - o ePub, PDF, MOBI, and More
  - Nln Health Physical Assessment Study Guide Compatibility with Devices
  - Nln Health Physical Assessment Study Guide Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - o Adjustable Fonts and Text Sizes of Nln Health Physical Assessment Study Guide
  - Highlighting and Note-Taking Nln Health Physical Assessment Study Guide
  - Interactive Elements Nln Health Physical Assessment Study Guide
- 8. Staying Engaged with Nln Health Physical Assessment Study Guide
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Nln Health Physical Assessment Study Guide
- 9. Balancing eBooks and Physical Books Nln Health Physical Assessment Study Guide
  - $\circ$  Benefits of a Digital Library
  - o Creating a Diverse Reading Collection Nln Health Physical Assessment Study Guide
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Nln Health Physical Assessment Study Guide
  - Setting Reading Goals Nln Health Physical Assessment Study Guide
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Nln Health Physical Assessment Study Guide
  - o Fact-Checking eBook Content of Nln Health Physical Assessment Study Guide
  - Distinguishing Credible Sources

- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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