Lab 5 vital signs Dr.wafaa

Terminology

- **Tachypnea –** increase respiratory rate over 20
- **Bradypnea –** decrease respiratory rate below 12
- **Dyspnea –** shortness of breath – difficulty in breathing
- **Apnea –** Periodic absence of breathing
- **Hyperventilation** – fast and deep respirations
- **Hypoventilation** – slow and shallow respirations

Respiration RR: One respiration consists of one inspiration and one expiration.

- The chest rises during inspiration (breathing in) and falls during expiration (breathing out).
- normal respiratory rate for adult is 12 – 20 breaths/min.
- Count each time the chest rises
- The best time to assess the patient's respirations is immediately after taking his pulse rate.
- Keep your fingertips over the radial artery, and don't tell the patient you're counting respirations.
- Count respirations by observing the rise and fall of the patient's chest as he breathes. Alternatively, position the patient's opposite arm across his chest and count respirations by feeling its rise and fall.
- Consider one rise and one fall as one respiration.
- Count respirations for 30 seconds and multiply by 2 or count for 60 seconds if respirations are irregular to account for variations in respiratory rate and pattern.
- Observe chest movements for depth of respirations. If the patient inhales a small volume of air, record this as shallow; if he inhales a large volume, record this as deep.

Blood Pressure: The measurement of the amount of force the blood exerts against the artery walls

- **Systolic pressure –** pressure exerted when the heart muscle is contracting
- **Diastolic pressure –** pressure exerted when the heart muscle is relaxing between beats
- Blood pressure is recorded as the systolic pressure on top and the diastolic pressure on the bottom (systolic /diastolic ex. 120/80.)
- Bp is measured in mm (millimeters) of hg (mercury)

NORMAL BLOOD PRESSURE

Average adult systolic range – 100 to 140

Average adult diastolic range – 60 to 90

ABNORMAL BLOOD PRESSURE

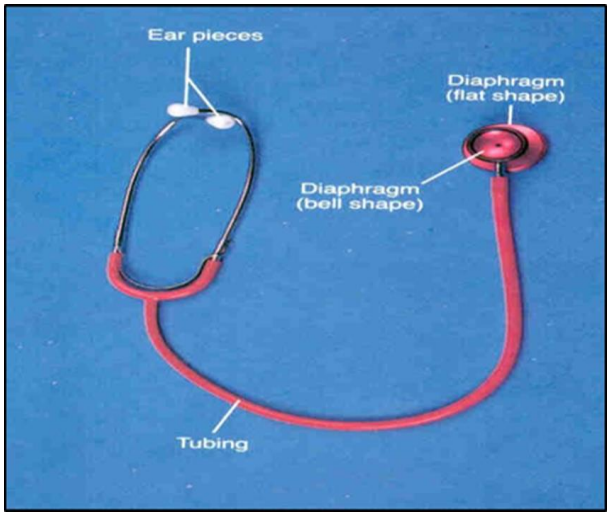
***Hypertension* –** measurements above the normal systolic or diastolic pressures

***Hypotension* –** measurements below the normal systolic or diastolic pressures

-Type of cuff

The proper name for a blood pressure cuff is ***sphygmomanometer***

Measuring of BP



Measuring of BP

Do not take a blood pressure on an arm with an iv, a cast, or a dialysis shunt.

O Do not take a blood pressure on the side that a person has had breast surgery on.

O Measure blood pressure with the person sitting or lying.

O Apply the cuff to the bare upper arm. Do not apply the cuff over clothing.

O Make sure the cuff is warm.

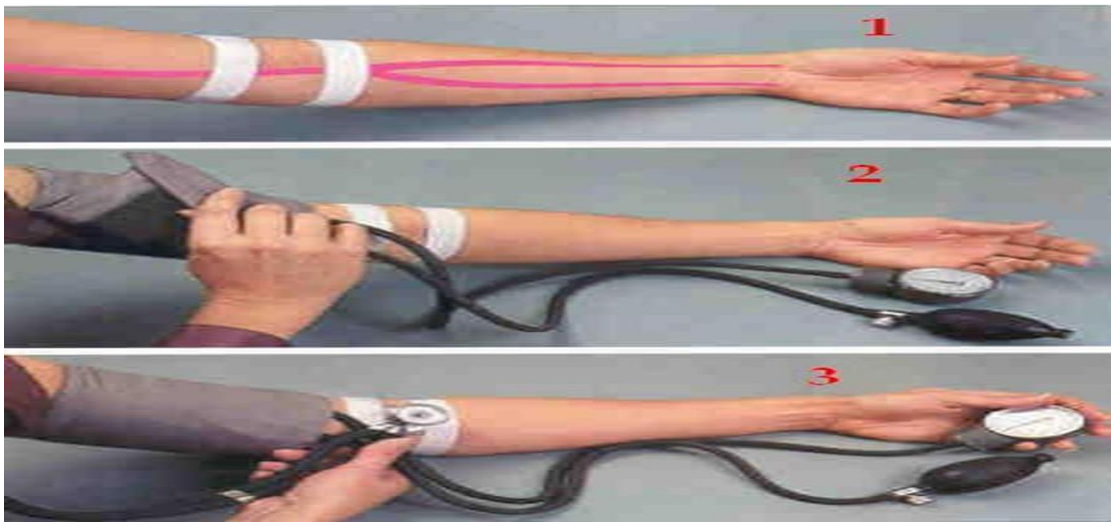
O Use a large cuff if necessary.

O Make sure the room is quiet.

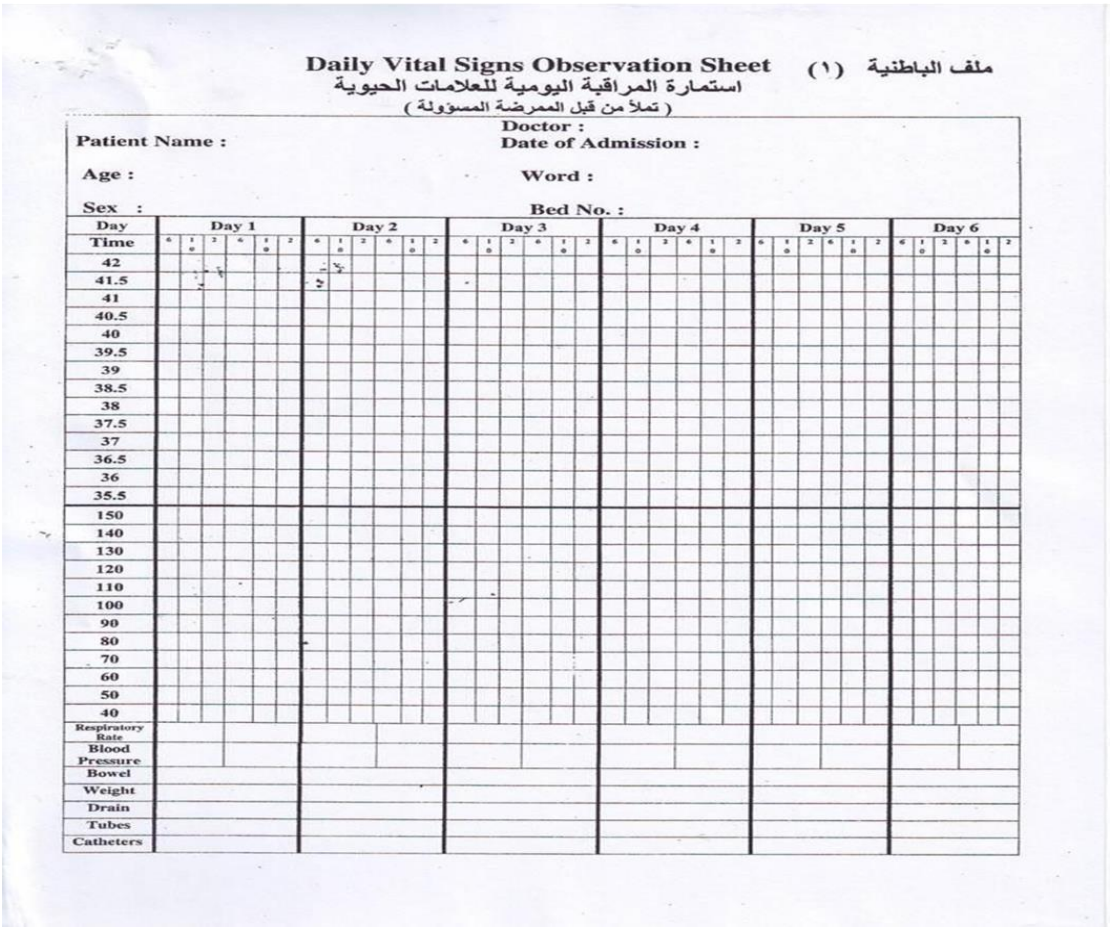
O If do not hear the blood pressure, wait 30 to 60 seconds and try again. If still can not hear it or are unsure of readings, have the other nurse check your measurements.

PROCEDURE FOR MEASURING BLOOD PRESSURE

1. Clean the stethoscope earpieces and diaphragm with alcohol.
2. Locate the brachial pulse. This is where the stethoscope will be placed.
3. Wrap the cuff above the elbow with the arrow pointing to the brachial artery. Fasten the cuff so it fits snugly.
4. Place the diaphragm of the stethoscope flat on the pulse site, holding it in place with the index and middle fingers of one hand.



5. Locate the radial pulse
6. Close the valve on the bp cuff by turning it to the right (clockwise).
7. Inflate the cuff until you can no longer feel the radial pulse ,Then inflate the cuff 30 mm hg beyond this point.
8. Deflate the cuff slowly by opening the valve slightly and turning it counter clockwise (to the left) with thumb and index finger.
9. Allow the air to escape slowly while listening for a pulse sound.
10. Note the reading at which hear the first clear, regular pulse sound. This number is the systolic pressure.
11. Continue listening until the sound disappears. This is the diastolic pressure. Note this reading.
12. Open the valve completely to deflate the cuff. Remove the cuff from the patient.



Daily Vital Signs Observation Sheet (١) ملف الباطنية
استمارة المراقبة اليومية للعلامات الحيوية
(تملأ من قبل الممرضة المسؤولة)

Patient Name : **Doctor :** **Date of Admission :**

Age : **Word :**

Sex : **Bed No. :**

Day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
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50						
40						
Respiratory Rate						
Blood Pressure						
Bowel						
Weight						
Drain						
Tubes						
Catheters						