

STUDENT'S NAME _____

DATE _____

FOR FACULTY USE ONLY

DATE _____

EDUCATOR'S NAME _____

PASS / FAIL



Checklist

Vital Signs: Assessing Blood Pressure

Step by Step

SATISFACTORY /

UNSATISFACTORY

EVALUATORS COMMENTS

Measuring Blood Pressure

Provide privacy as needed*

Introduce yourself to the client.*

Perform hand hygiene and put on appropriate PPE if indicated*

Verify client identification*

Determine whether the client has allergies.*

Provide client education.*

Select the appropriate arm to apply the cuff.

Place the client lying or sitting position,

Support the forearm at the level of the heart with the palm of the hand upward.

Visualize the client's brachial artery by removing any clothes or bed linens.

Choose the appropriate cuff size.

Palpate the brachial artery, apply the cuff with the center of the cuff bladder over the brachial artery, midway on the arm at least 1 inch above the antecubital.

Line the artery marking on the cuff with the brachial artery, with the tubing extending from the edge of the cuff. Wrap the cuff around the arm smoothly and snugly and fasten it.

With the gauge at eye level, verify that the needle on the aneroid manometer is at the zero mark.

Palpate the brachial artery

Tighten the screw valve on the air pump and inflate the cuff. Continue to palpate the brachial artery and note the number on the gauge when the pulse is no longer felt,

**Document the relevant information (BP, site, and any interventions) in the client's medical record.*

Step by Step

	SATISFACTORY / UNSATISFACTORY	EVALUATORS COMMENTS
Deflate the cuff slowly, wait 1 minute. Leave the cuff in place.		
Position yourself no more than 3 feet away from the gauge.		
Clean the earpieces, bell, and diaphragm of the stethoscope with an alcohol pad.		
Place the earpieces in your ear and the diaphragm or bell firmly over the brachial artery.		
Ensure that the stethoscope is not touching clothing or the cuff.		
Tighten the screw valve on the air pump and inflate the cuff, pumping the pressure to 30 mmHg over the estimated systolic pressure.		
Open the valve and slowly release the air, dropping the gauge about 2 to 3 mm per second.		
Identify the number on the gauge when the first faint, clear sound is heard which slowly increases in intensity.		
Continue to release the air, until the sound completely disappears. Note the number on the gauge when this occurs,		
Deflate and remove the cuff.		
Position the client comfortably and cover.		
Clean the bell and diaphragm of the stethoscope with alcohol pad. Clean and store the cuff per policy.		
Ensure that the client is in a safe position prior to leaving the room and has the call light within reach.*		
Compare the findings with the client's baseline.		

**Document the relevant information (BP, site, and any interventions) in the client's medical record.*

References

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017). Fundamentals of nursing (9th ed.). St. Louis, MO: Elsevier, pp. 525-528

Taylor, C., Lynn, P. and Bartlett, J. (2019). Fundamentals of Nursing (9th ed.). Philadelphia: Wolters Kluwer, pp. 681-685