

## Week 2 Vital Sign Assignment

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Temporal pulse: To check the elderly for vision loss or headaches assessment.

Carotid pulse: Assessment of the carotid arteries provides information about the function and quality of blood flowing through the artery. There are 2 steps. First an RN would auscultate then palpate the artery. The carotid pulse is part of the head to toe assessment.

Brachial pulse: An RN would check the brachial pulse if it was difficult to feel the radial pulse on a child. This is part of the head to toe assessment.

Radial pulse: The radial pulse is used because it is generally very easy to find. This is part of the head to toe assessment.

Ulnar pulse: An RN would take an ulnar pulse to evaluate neurovascular injuries and determine normal function.

Dorsalis pedis pulse: An RN would assess a dorsalis pedis pulse because a diminished dorsalis pedis pulse may indicate vascular insufficiency. Although due to differences in the anterior tibialis termination, some people may have congenitally non-palpable dorsal pedis pulse. This is part of the head to toe assessment.

Apical pulse: If there is a family history of heart disease or pt has been experiencing s/s of heart disease such as chest pain, SOB, irregular heartbeat and fatigue.

Femoral pulse: An RN could assess a child who has (COA) Aortic Coarctation. COA is a congenital narrowing of a short section of the aorta. It must be treated quickly because it could

cause high blood pressure or dissection or rupture of the aorta. This is part of the head to toe assessment.

Popliteal pulse: An RN would take a pulse of the popliteal artery to evaluate circulation to the lower leg and foot, especially when peripheral pulses are diminished which could indicate peripheral vascular disease or arterial blockages of the lower extremities.

Posterior Tibial pulse: An RN would take a posterior tibial Pulse to assess the blood flow and perfusion to the plantar aspect of the foot. This is part of the head to toe assessment.