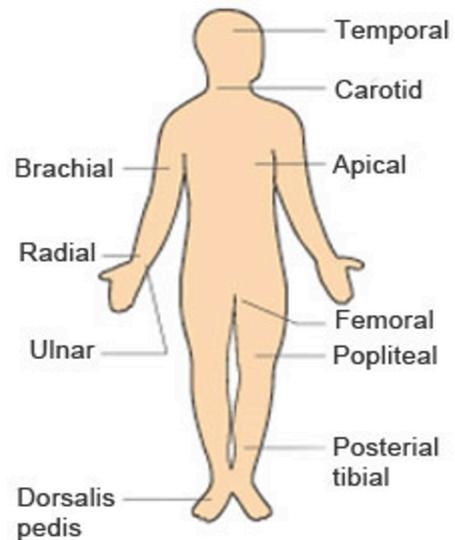


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Unit 2: Online Vital Signs

Instructions: For each pulse point, why would we, as an RN, use the specific pulse point (generalized reason or specific situation)



**Temporal-** The Site we check in premature infants, it's the most accessible site that is detectable.

**Carotid-** When we suspect a person/patient/client's heart has stopped beating, which is when we check this pulse point to see if CPR is needed.

**Brachial** - This is the area we listen to when taking blood pressure measurements.

**Apical-** Before giving a cardiac medication, we (as nurses) would take an apical pulse to ensure accuracy of the bpm and rhythm.

**Radial-** The most common way of checking one's pulse, when we do assessments/vitals, we would do heart rate here.

**Ulnar-** Less common, but also used to check circulation to the hand (Allen's test) to ensure proper blood supply to the hand if the radial artery is being used.

**Femoral-** Could be used to assess circulation to the leg, but also a site to assess a pulse when other sites are not palpable.

**Popliteal-** We could check this site after a patient had vascular surgery, possibly like a femoral bypass, which would confirm blood flow to the leg.

**Dorsalis pedis-** Checked to see if blood flow is reaching the foot, usually in patients with diabetes or poor circulation problems, to ensure good blood flow all the way down.

**Posterial tibial-** Also, to check circulation in the lower extremities, we could check this specific maybe if we suspect DVT, this pulse can give us information about the blood flow below the knee.

