

# NURSING FOUNDATIONS 2025

## **Unit 2**

### **Chapter 29: Vital Signs**

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Students need to learn how to assess temperature, pulse, blood pressure, respiratory rate, oxygen saturation and pain. These are referred to as vital signs because these measurements indicate the effectiveness of the circulatory, respiratory, and neural body functions. Vital sign measurements assist nurses to identify and evaluate the client's response to an intervention and provide nurses with physiological measurements used as a basis for clinical problem solving.

- Whenever a client enters a health care facility
- Change in condition - from not feeling well to severe change in condition
- Before or after medication
- Before, during and after blood transfusion
- Before, during and after surgical procedure
- See Box 29.2 (Pg. 503)

## GUIDELINES FOR MEASURING VITAL SIGNS

2

It is important to establish a baseline for the client.

Changes in vital signs, either positive or negative, will provide you with valuable information regarding a client's health status.

Must be measured correctly

Equipment should be working and appropriate size for client

Must be understood and interpreted

Must be communicated

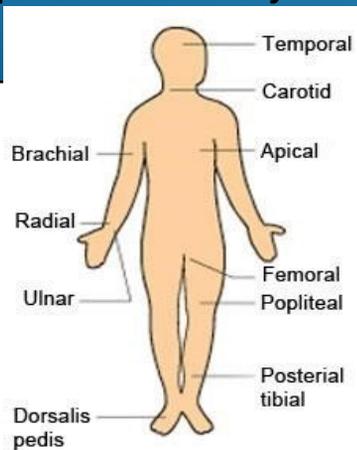
Can be delegated

## GUIDELINES FOR MEASURING VITAL SIGNS CONTINUED

3

You will want to make sure the equipment is in good working order and that you have selected the correct blood pressure (BP) cuff size and the appropriate device to measure temperature.

Vital signs can be delegated to unlicensed assistive personnel (UAP) but **the RN is responsible for interpretation and analysis of the data.**



"Pulse sites on the body"

4

These are the pulse sites on the body. The most frequent way a pulse is obtained in via the radial pulse.

**Your assignment (to be completed and placed in the “Week 2: Online Vital Signs Assignment” dropbox on Edvance360 by 8/28/2025 at 0800) is as follows:** -For each pulse site on the above image, list one reason why you as an RN may choose to use this site for pulse assessment. You can either give a generalized reason or a specific patient situation. Please put the pulse site and answer in a word document and include your name.

□ <https://www.youtube.com/watch?v=bHXvhOO0hYc&t=>

As an RN I would need to get a temporal pulse to assess circulation to the head and face.

Carotid: If a Pt goes into cardiac arrest without a doppler this can be the best way to find a pulse.

Brachial: Blood Pressure reading, when you take a blood pressure reading you are listening for the brachial pulse.

Apical: To assess the sound of the heart

Radial: For routine Vital signs as a RN the radial pulse is easiest for easy access, and to see rate, rhythm, and strength.

Ulnar: To check for peripheral circulation especially in a trauma or with lots of swelling.

Femoral: For cardiac arrest with a doppler.

Popliteal: Assess circulation to the lower leg, if this pulse is weak while the femoral is strong it could show a possible blockage.

Posterial: Assess the circulation of the foot/ankle especially in diabetics.

Dorsalis Pedis: To assess circulation to the foot, especially with a leg injury.

- Doppler video
- [https://www.youtube.com/watch?v=ON9FYOBpNc&index=2&list=PL3Q2UyX9\\_s7MCjFwf66cbPc6xvFiFecyL](https://www.youtube.com/watch?v=ON9FYOBpNc&index=2&list=PL3Q2UyX9_s7MCjFwf66cbPc6xvFiFecyL)

WATCH THIS VIDEO RELATED TO BLOOD  
PRESSURE USING A DOPPLER

6

- Always ask pain level when talking with patient upon taking VS or assessment
- Document Q 1 hour if in pain and 1 hour after pain medication, or
- If patient not in pain then document pain assessment Q 8 hours
- FLACC
- Verbal = 0 to 10
- Wong-Baker - face scale

## PAIN ASSESSMENT

7

FLACC for unconscious patient or one who cannot verbalize

F face

L legs

A activity

C cry

C consolability

Wong Baker for kids

Will do more in depth pain content later in semester