2 VITAL SIGNS

Chapter 2 focuses on the knowledge and skills needed to measure temperature, pulses, respirations, blood pressure, and oxygen saturation using a variety of instruments and approaches.

SUGGESTED DISCUSSION QUESTIONS, LAB, AND CLINICAL ACTIVITIES

1. Compare typical vital sign ranges for infants, children, adults, and older adults.
2. Why should the axilla be dry prior to the nurse taking an axillary temperature?
3. How many minutes should a thermometer be left in place for oral, rectal, and axillary measurement?
4. What should the nurse be doing while a rectal thermometer is registering?
5. When should the nurse take an apical rather than a radial pulse?
6. How can there be a difference between the radial and apical pulse?
7. Besides counting the heart rate, what is the purpose of taking a pulse in the temporal, brachial, femoral, popliteal, and pedal arteries?
8. How would one describe a pulse that is weaker than usual? Stronger than usual?
9. What is the clinical significance of the presence of only one of the two pedal pulses?
10. Besides rate, what other observations are made when assessing respirations?
11. Give students lists of sample vital signs. Ask them to assign the proper medical terminology for each sign (e.g., febrile, bradycardic).
12. Have students list three client situations in which it is best to measure an oral, rectal, tympanic, and axillary temperature.
13. Give students anatomical drawings and have them label all significant pulse sites.
14. Have students take blood pressures on each other using cuffs that are of various sizes and with the arm in a variety of positions. Also compare the results from manual and automatic devices if available. Ask them to report the relative direction of their findings.
15. Discuss how specific clients exhibit behaviors indicative of their vital signs.
16. Practice reading various types of thermometers and sphygmomanometers.
17. What would be appropriate actions and statements to the client if the nurse has difficulty finding a pulse or hearing a blood pressure?
18. How do the vital signs students have recorded compare with the client's previous values?

How does the nurse interpret these findings?

19. Unless there are orders to the contrary, which vital sign findings should be immediately reported to the physician?

FOCUSING ON CLINICAL THINKING
Consider This

1. What should you do if the client has been eating or smoking within the past 30 minutes and you wish to take the temperature?
2. How should you proceed if the client is not cooperative or able to understand your instructions regarding the use of an oral thermometer?
3. Why is it important to know by what route the last temperature reading was taken, when, and what the resultant temperature reading was? Give several reasons.
4. In an emergency, the radial pulse may not be accessible or palpable. What other two sites are useful in such situations?
5. When assessing pulses in the foot, what is the next action to take if neither the posterior tibial nor dorsalis pedis pulse can be felt?
6. While you are counting respirations after counting the client's pulse, the client asks why it is taking so long. What would be an appropriate response?
7. While you are releasing the cuff and auscultating the blood pressure, the client coughs loudly and jerks the arm, resulting in your inability to accurately hear Korotkoff's sounds. In detail, how should you proceed?
8. The pulse oximeter on the client's finger reads 85%. The client's skin is warm and has normal color. The client is awake and oriented, temperature is 98.8°F, apical pulse is 78, and blood pressure is 136/84. What would be your next actions?