Taking a set of observations (vital signs)

To begin:

WIPE

- Wash hands
- Introduce self
- Identify patient
- Permission – gain consent for the exam
- Position – seated
- Pain – ask if the patient is in pain
- Privacy – ensure curtains/doors are closed
- Exposure – hands, upper arm and ears accessible – if someone wears an arm or head covering you should ask if they are happy to be examined, and ask the patient to expose the arm and ear as comfortable.

General inspection and active observation

Patient:

Look for	**Example of why**
General appearance	See if the patient is alert, in pain, generally appearing well or unwell

Around the bed:

Look for	**Examples of why**
Treatments/medications	Oxygen, IV fluids, other medication, nil by mouth signs
Patient equipment	Walking aids, glasses, hearing aids
Observation chart	If this is available, look at what their most recent observations were and when they were taken.

Observations

Vital sign	How	Assessing for/associated with
Heart rate	Take a pulse, count for 15s and x4 to get beats per min	Assess if the heart rate is too high or too low. Also note if rhythm is regular/irregular Normal: 60-100 beats per min
Blood pressure	Choose appropriate size cuff for patients arm. Place cuff around upper arm, lining up the brachial artery with the cuff marker. patient should be sat in a relaxed position on a chair, with their arm at heart level Automatic – press 'go' and wait for a reading Manual – 1. Palpate radial artery whilst inflating the cuff. When the pulse disappears, this is an estimate of the systolic blood pressure. Deflate the cuff. 2. Place stethoscope over the brachial artery. Re-inflate cuff 20-30mmhg over the patient's estimated systolic blood pressure. 3. Slowly deflate the cuff, listening for the appearance and disappearance of Korotkoff sounds – these correlate to systolic and diastolic blood pressures, respectively. 4. Note the pressure readings on the dial for both points.	Assess if the blood pressure is too high or low. Compare to what is normal for the patient. Take repeat readings if unsure. Normal: SBP: 90-120 mmHg DBP: 60-90 mmHg
Respiratory rate	Count patient's chest movements for 30s and x2 to get breaths per min. Don't tell you patient you're counting their RR as it may change their breathing (Useful to count	Assess if the respiratory rate is too high or too low. Normal: 12-20 breaths per min

	respiratory rate after taking a heart rate whilst still holding the patients pulse)	
Pulse oximetry (using a finger)	Place the probe on a finger and wait a few seconds. Note if they're on any supplemental oxygen.	Low saturations may be associated with hypoxia. Normal: >94% N.b. readings can be inaccurate in people wearing nail polish, with darker skin etc.
Temperature (using an ear)	Using a disposable cap, place the thermometer in the patient's ear. Press the button then wait for a few seconds to get a reading.	High temperature (pyrexia) usually caused by infection Normal: 36.1-38.0°C
Consciousness level (ACVPU)	Assess if: • The patient appears alert and normal for them – **alert** • The patient is alert but has new confusion – **confused** • The patient responds to being talked to or verbal commands – **voice** • The patient responds to a painful stimulus – **pain** • The patient does not respond – **unresponsive**	Further down the scale usually correlates with worse pathology.

To finish

- Ensure the patient is dressed and comfortable
- Wash hands