

Study Guide: Measuring Vital Signs (Chapter 18)

1. Key Concepts

- **Vital Signs (VS):** Temperature, pulse, respirations, and blood pressure (BP).
- **Additional factors:** Pain, oxygen saturation, smoking status, emotional distress.
- **Baseline importance:** Compare all VSs to patient's usual readings, not just standard norms.

Key Points from Chapter 18: Measuring Vital Signs

- Rectal measurements represent core temperatures, while oral and axillary reflect surface temperatures.
- An adult's normal internal (core) temperature ranges from about 36.1°C to 38.2°C (97°F to 100.8°F).
- Core temperature is typically 0.6°C to 1.2°C (1°F to 2°F) higher than surface temperature.
- Older adults may be unable to reach the fever temperature range necessary to develop a strong inflammatory response.
- Hyperpyrexia (fever above 41.0°C / 105.8°F) is dangerous and requires intervention to prevent brain damage, vascular collapse, or death.
- Hyperthermia occurs when body temperature rises above normal but the hypothalamus does NOT reset the set point like in fever; it happens when the body cannot promote heat loss fast enough.
- To convert Fahrenheit to Celsius: $(^{\circ}\text{F} - 32) \times 5/9$.
- To convert Celsius to Fahrenheit: $(^{\circ}\text{C} \times 9/5) + 32$.
- A baseline is important for evaluating changes in physiological status.
- Vital signs should always be interpreted in the context of the entire patient assessment, not just isolated numbers.
- Respiratory rate is a measure of general condition, but rate alone does not indicate adequacy; depth, rhythm, and effort must also be assessed.
- Changes in respiratory rate are an early indication of clinical deterioration.
- The primary stimulus for breathing is the level of CO₂ in the blood.
- For accuracy, count respirations for 60 seconds for new patients or when irregularities are present.
- Older adults have lower body temperatures and may have different normal ranges than younger adults.
- Pulse deficits (apical vs. radial differences) indicate heart irregularities and should be reported.
- Apical pulse is the most accurate; use when radial pulse is weak/irregular or in infants and young children.
- BP assessment: Use the bell of the stethoscope for better accuracy at diastolic pressures.
- Baseline VSs must be established at admission or initial contact for accurate comparisons later.

Measuring Vital Signs Study Guide Answer Key

**Linda A. LaCharity, Candice K.
Kumagai, Barbara Bartz**



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Murphy,Marilyn J. Hockenberry,Kelley Ward,2000-11

Nursing Assistant Fundamentals June Eastmond,1997-02

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