

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 CO_2 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

Connie Will-Black, Judith Eighmy

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Foundations of Nursing: Enrolled Nurses Susie Gray, Leanne Ferris, Lois Elaine White, Gena Duncan, Wendy Baumle, 2018-08-31 Designed for the Diploma of Nursing Foundations of Nursing Enrolled Nurses Australia and New Zealand edition is mapped to the HLT54115 training package competencies and aligns to the revised Standards for Practice for the Enrolled Nurse Written to equip the enrolled nurse with current knowledge and basic problem solving and critical thinking skills to successfully meet the demanding challenges of today's health care the text clearly explains concepts and definitions and scaffolds knowledge The student friendly text provides a clear and fresh approach to the study of nursing it is straightforward and heavily illustrated with colour photos of procedures **Prioritization, Delegation, and Assignment** Linda A. LaCharity, Candice K. Kumagai, Barbara Bartz, 2013-12-02 The only NCLEX review book on the market with a focus on prioritization delegation and patient assignment just like the current NCLEX Examination itself Using a unique simple to complex approach Prioritization Delegation and Assignment Practice Exercises for the NCLEX Examination 3rd

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