

- **15 minute test**
- Make sure you have your own watch
- Watch the video and review the chapter.
- **Be prepared by knowing the normal ranges for each vital sign.**
- Remember the **importance of assessments**. The contraindications of checking blood pressure on certain arm, feet flat on the floor, the importance to know difference between child and adult for tympanic temperatures, the questions to ask before an oral temperature, etc.
- Remember about systolic range why we do it and how we calculate it. So everyone is on same page remember we are adding 30.

***** You will bring into the test a sheet of paper with the following written: *****

Patient: _____ **Date:** _____ **Time:** _____

Temperature:

Radial Pulse:

Respirations:

Apical Pulse:

Pulse last felt at:

(Math calculation)

Systolic Range:

Blood Pressure:

Vital signs will be documented with: time and date, patient's name, your signature (legible) and title (your title is SVN)

* A bottle of antiseptic hand rub will be available so that you can perform hand hygiene. Know when to apply.

You will perform either an oral or tympanic temperature

- Dual headed stethoscopes will be used for auscultation of Apical Pulse and Blood Pressure.
- Instructors will count pulse and respirations along with you but we do not have to count using the same watch.

Below are the discrepancies from what you may obtain and the instructor assesses.

- Radial Pulse** – 4 beats discrepancy between student and instructor for the 1 minute count
- Respirations** – 3 breaths discrepancy between student and instructor for the 1 minute count
- Apical count** – 5 beats discrepancy between student and instructor for the 1 minute count
- Blood Pressure** – 4mmHg discrepancy between student and instructor for systolic and diastolic

If you were out of range for any of the measurements you will go on to the next assessment and come back to the missed one if time permits. You must be able to get a count within range for each vital sign component to complete the skill.

We will not be testing on pain or oxygen saturation (just be aware that pain is the 5th VS and is assessed each time the other VS are)

Rubric:

Step A, B and C are required for this skill. What cannot be demonstrated must be verbalized.

Example:

Step A: Perform the task according to protocol.

___ Mentally review the steps of the task beforehand. .

>>> Make the statement “ I will mentally review the steps of the task beforehand. <<<

Standard Steps for all Nursing Procedures {bolded areas – essential steps}	
<u>At the Beginning of the Procedure:</u>	
<u>Step A: Perform the task according to protocol.</u>	
___ Mentally review the steps of the task beforehand.	
___ Ask for help when uncertain how to perform a task.	
___ Will plan for time management.	
___ Will plan for delivery of safe care.	
<u>Step B: Check the order, collect the equipment and supplies, and wash your hands.</u>	
___ Verify the procedure is to be done for the patient. Verify physician orders.	
___ Check facilities Policies & Procedures manual for accepted method of performing the procedure.	
___ Collect equipment and supplies and take to patient’s room.	
___ Perform hand hygiene.	
	<u>Step C: Identify and prepare the patient.</u>
	___ Greet the patient and identify yourself using your title.
	___ Identify patient using two patient identifiers and the patients I.D. band.
	___ Explain procedure to the patient using terms the patient can understand.
	___ Elicit questions and answer them clearly.
	___ Provide necessary teaching related to the procedure to be done.
	___ Perform hand hygiene.