Student name ----------

Teacher name ---------- ----------
Date / / 2021-2022

VITAL SIGNS – ASSESSING RADIAL PULSE

No.	STEPS	RATIONAL	D	M	A	S	I
			0	1	2	3	4
1	**Prepare procedure equipment**: • Patient's medical record • Wrist watch with second hand or digital display • Pen, observation chart • Hand rub gel	Organization facilitating accurate skill performance					
2	Verbally confirm the identity of the client by asking for their full name and date of birth. If client unable to confirm, check identity with family.	Identifying the patient ensures the right patient receives the intervention and helps prevent errors.					
3	Greet the client, introduce yourself as a staff member and take permission.	To promote mutual respect and put client at ease.					
4	Explain the purpose and the procedure to the client.	Providing information fasters cooperation and understanding					
5	Assess patient for signs and symptoms of altered stroke volume such as dyspnea, fatigue, chest pain, syncope, palpitations, distended jugular vein, dependent edema, cyanosis, skin pallor.	Physical signs and symptoms may indicate alteration in cardiac function.					
6	Perform hand hygiene	Reduce transmission of microorganism					
7	Draw curtain around bed and/or close door.	Maintain privacy					
8	Help patient assume a supine and sitting position	Provides easy access to pulse sites					
9	Determine the previous baseline of PR (if available).	Allows nurse to assess for change in condition and provides comparison with future pulse measurements.					
10	If sitting, bend patient's elbow 90 degree and support lower arm on chair or on nurse arm.	Relaxed position of lower arm permits full exposure of artery to palpation.					
11	Place tips of first two fingers of hand over groove along radial or thumb side of patient's inner wrist.	Fingertips are the most sensitive parts of hand to palpate arterial pulsation.					
12	Lightly compress against radius, obliterate pulse initially and then relax pressure so pulse becomes easily palpable.	Pulse is more accurately assessed with moderate pressure. Too much pressure occludes pulse and impairs blood flow.					
	After pulse, can be felt, look at watch's second	Rate is determined accurately only after					

13	hand and begin to count rate; when second -hand hits number on dial, start counting with 0, then 1, 2 and so on.	nurse is assured pulse can be palpated. Timing begins with 0. Count of 1 is first beat palpated after timing begins.					
14	If pulse is regular count rate for 30s and multiply total by 2. If the pulse is irregular count for 1 full minute.	A 30s is accurate for rapid, slow or regular pulse rate.					
15	Discuss findings with patient as needed	Promotes participation in care and understanding of health status.					
16	Dispose equipment properly	To prevent the spread of infection					
17	Compare readings with previous baseline	Allows assessment for changes in patient condition.					
18	Perform hand hygiene	Reduces transmission of microorganism					
19	Record pulse rate on observation chart Reporting abnormal finding to nurse in charge or medical doctors.	To save patient's health information. To assess previous base line of the radial pulse.					

D = Dependent, M= Marginal, A= Assisted, S=Supervised, I= Independent.