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

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

VITAL SIGNS – ASSESSING RESPIRATION RATE

No	STEPS	RATIONAL	D	M	A	S	I
			0	1	2	3	4
1	**Prepare procedure equipment**: • Patient 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	Do not explain the purpose and the procedure to the client.	Providing information fasters cooperation and understanding					
5	Determine the needs to assess patient's respirations like : **A-**note risk factors for respiration alterations **B-**assess for signs and symptoms of respiration alteration such as bluish, cyanotic appearance of nail beds, lips, mucous membranes and skin, restlessness, irritability and confusion,	**A-**Cretin conditions place patient at risk of alterations in ventilation detected by changes in RR ,fever, pain, anxiety, diseases in chest wall and muscles **B-**Physical signs and symptoms may indicate alterations in respiratory status related to ventilation					
6	Assess pertinent laboratory value: a. ABGs b. Pulse oximetry (SPO2) c. Full blood count (FBC)	A-Arterial blood gases measure blood PH, Pao2, PaCO2, Sao2 which reflect patient O2 saturation. B-SPO2 less than 85%is often accompanied by changes in RR, depth, and rhythm. C- Which reflect the patient's capacity to carry oxygen					
7	Determine the previous baseline of RR (if available).	Allows nurse to assess for change in condition and provides comparison with					

		future respiration measurements.					
8	Be sure patient in comfortable position preferably sitting or lying with the head of bed elevated 45-60 degrees	Sitting erect promotes full ventilatory movement					
9	Draw Curtin around bed or close door, perform hand hygiene.	Maintain privacy, prevents transmission of microorganism					
10	Be sure patient's chest is visible. If necessary move bedclothes or gown	Ensures clear view of chest and abdomen movement					
11	Place the patient arm in relaxed position across the abdomen or lower chest or place the nurse hand directly over patient's upper abdomen	Allows RR assessment to be inconspicuous, patient or nurses hand rises and falls during respiration cycle.					
12	Observe the complete respiration cycle (one inspiration and one expiration).	Rate is accurately determined only after nurse has viewed respiration cycle					
13	After the cycle is observed, look at watch's second hand and being to count rate , when the second hand hits number on dial, being timeframe, counting 1 with full respiration cycle	Timing being with count of 1 respiration occur more slowly than pulse thus timing dose not being with 0.					
14	If rhythm is regular count number of respiration in 30s and multiply by 2 if the rhythm is irregular count for 1 full minute.	RR is equivalent to number of respiration per minute suspected irregularities require assessment for at least 1 minute.					
15	Note depth of respiration subjectively assessed by observing degree of chest wall movement while counting rate. Also objectively assess depth by palpating chest wall excursion or auscultations the posterior thorax after rate has been counted, depth is describe as shallow, normal, deep.	Character of ventilatory movement may reveal specific disease state restricting volume of air from moving into and out of lung					
16	Replace bedclothes and patient gown	Promote sense of wellbeing					
17	Perform hand hygiene	Reduces transmission of microorganism					
18	Discuss finding with patient as needed	Promote participation in care and understand health status					
19	Compare respiration with patient previous baseline and normal rate, rhythm and depth.	Allows assessment for changes in Patient. condition.					
20	Record RR and character in nurses notes and observation chart Report abnormal finding	Assess for environmental factors in the home that may influence patient RR such as secondhand smoke, poor ventilation or gas fumes.					

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