

NSG 3100: UNIT 3 HEMODYNAMICS

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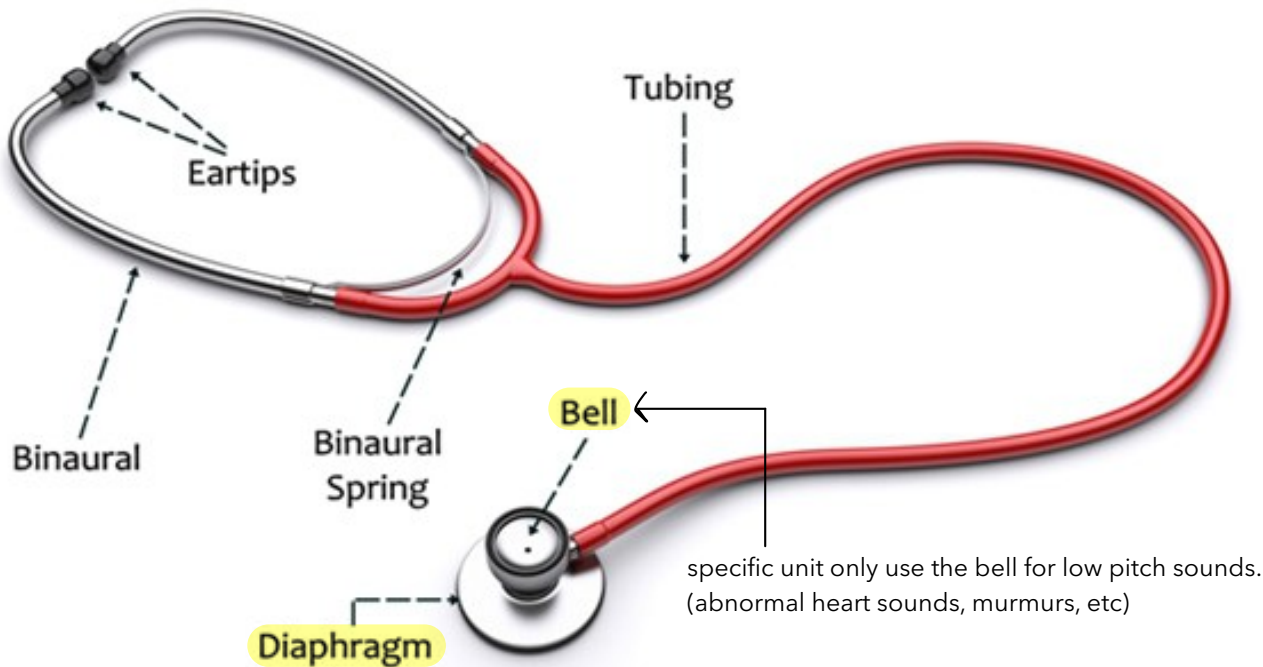
Guiding Principle

Don't treat the number, treat the patient!

(many patients can be asymptomatic with VS, so its best to treat the patient's problems not based on the machines).



Stethoscope



high pitch sounds (breath sounds, normal heart sounds, bowel sounds)

X
get VS if patient come back to your floor.

always get full sets of VS!

BOX 29-1

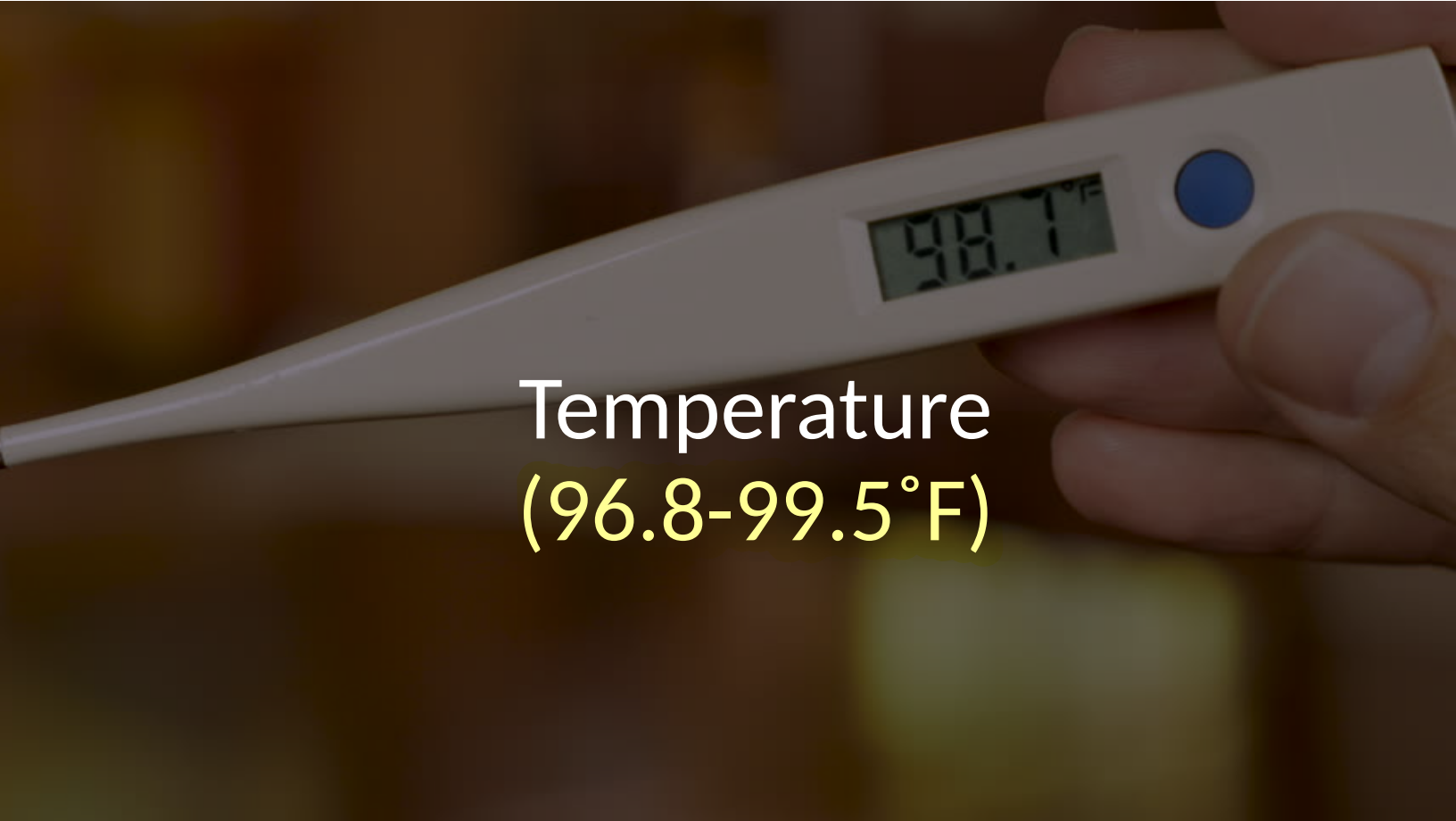
Times to Assess Vital Signs

- On admission to a health care agency to obtain baseline data
- When a client has a change in health status or reports symptoms such as chest pain or feeling hot or faint
- Before and after surgery or an invasive procedure
- Before and/or after the administration of a medication that could affect the respiratory or cardiovascular systems; for example, before giving a digitalis preparation
- Before and after any nursing intervention that could affect the vital signs (e.g., ambulating a client who has been on bed rest)

MDs and RNs
will use the
VS as normal
baseline data.

before
administer,
check the
target
organ VS.

compare VS for any concern affects.



Temperature
(96.8-99.5°F)

both population groups
are the mostly affected
with temperature loss in
their head and feet.

Factors Affecting Temperature

1. **Age**- very young & very old have issues with extreme changes
2. **Diurnal variations** (circadian rhythms)- temp varies during the day with the highest temp between 4-6pm and the lowest temp between 4-6am.
3. **Exercise**- can increase temp up to 101-104 degrees rectally
4. **Hormones**-progesterone secretion at time of ovulation raises body temp by 0.5-1 degree above baseline
5. **Stress**- elevation in temp d/t sympathetic nervous system activation
6. **Environment**- appropriate dress

high corticosteroids levels



Temperature Regulation

- When the **body becomes too cold**:
 1. Shivering increases heat production
 2. Sweating is inhibited to decrease heat loss
 3. **Vasoconstriction** decreases heat loss —————> less blood flow will go to the skin and more will go to the body as core temperature.
- When the **body becomes too hot**:
 1. Sweating is initiated —————> tries to get rid of heat ASAP.
 2. **Vasodilation** occurs

Routes

X change the site, if doubt!

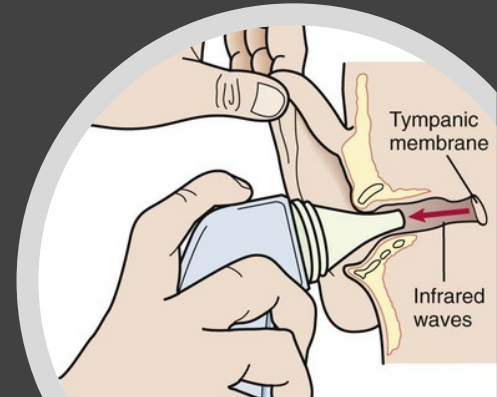
X initial assessment: ask them "if they have smoked, ate, or drink or exercise in the past 30 minutes?"

- Oral (most common site)
- Rectal (most reliable result)
- Axillary
- Tympanic
- Temporal

can give higher degree. don't add or subtract #, record it exactly.

reliable, if done right.... best for core temperature measuring.

not accurate, if not done right.



Clinical Manifestations

Hyperthermia

- **Onset (Chill):** ↑HR, ↑RR, Shivering, Cold skin
Complaints of feeling cold, Cyanotic nail beds, “Gooseflesh” appearance, Cessation of Sweating
- **Course (Plateau):** absence of chills, skin that feels warm, photosensitivity, glassy-eye appearance, ↑ HR, RR, thirst, mild to severe dehydration, drowsiness, restlessness, delirium, lesions of the mouth, loss of appetite, malaise, weakness, aching muscles
- **Defervescence (Flush):** skin is flushed and warm, sweating, decreased shivering, possible dehydration

Hypothermia

- ↓temp. pulse, respirations, UO
- Severe shivering (initially)
- Feels of cold and chills
- Pale, cool, waxy skin
- Frostbite
- Hypotension
- Lack of muscle coordination
- Disorientation
- Drowsiness progressing to coma

Nursing Interventions

Hyperthermia

- Remove excess blankets
- Adequate nutrition and fluids to meet increase metabolic demand
- Reduce physical activity to limit heat production
- Administer antipyretics
- Provide oral hygiene to keep mucous membranes moist
- Provide a tepid sponge bath

Hypothermia

- Warm environment
- Warm blankets
- Keep limbs close to body
- Cover head and feet
- Warm oral or IV fluids
- Warming pads/devices

A close-up photograph of a person's hand being held by another hand. The hand being held is the left hand, with fingers slightly curled. The hand holding it is the right hand, with fingers spread. The background is a plain, light gray. Overlaid on the image is the text 'Pulse' in white, and '(60-100 bpm)' in yellow, both centered over the palm area.

Pulse

(60-100 bpm)

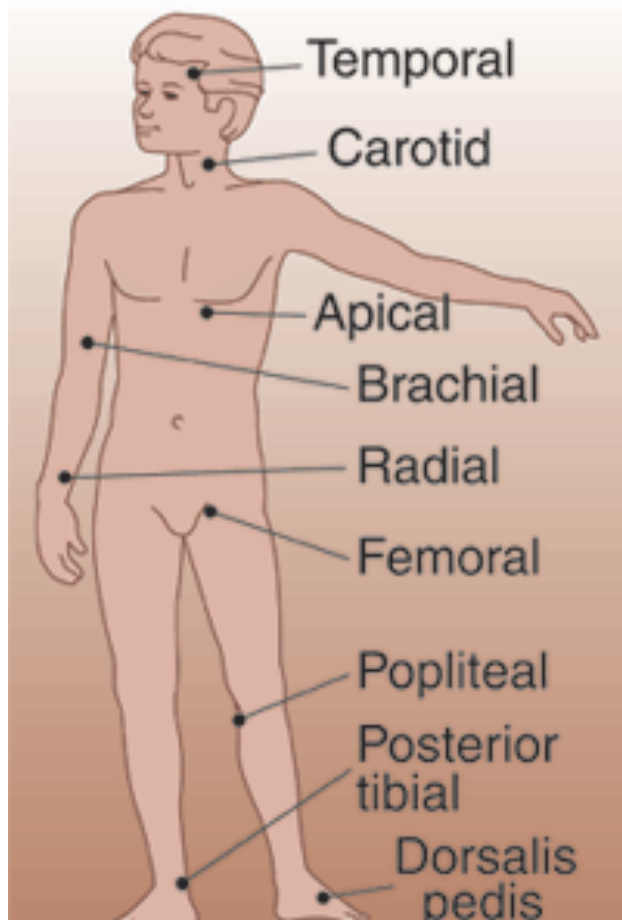
Factors Affecting Pulse

- **Age:** HR decreases with age —————> toddlers usually have HR of 110-120 bpm.
- **Sex:** males have lower HR after puberty
- **Exercise:** HR increases with activity
- **Fever:** HR increases with fever
- **Medications:** Digoxin —————> slows the HR by targeting the heart rhythm.
- **Hypovolemia/dehydration:** HR increases
- **Stress:** HR increases
- **Position:** HR increases with standing
- **Pathology:** heart conditions and those that impair oxygenation

↓
HD and RD mostly affected your BP.

Sites

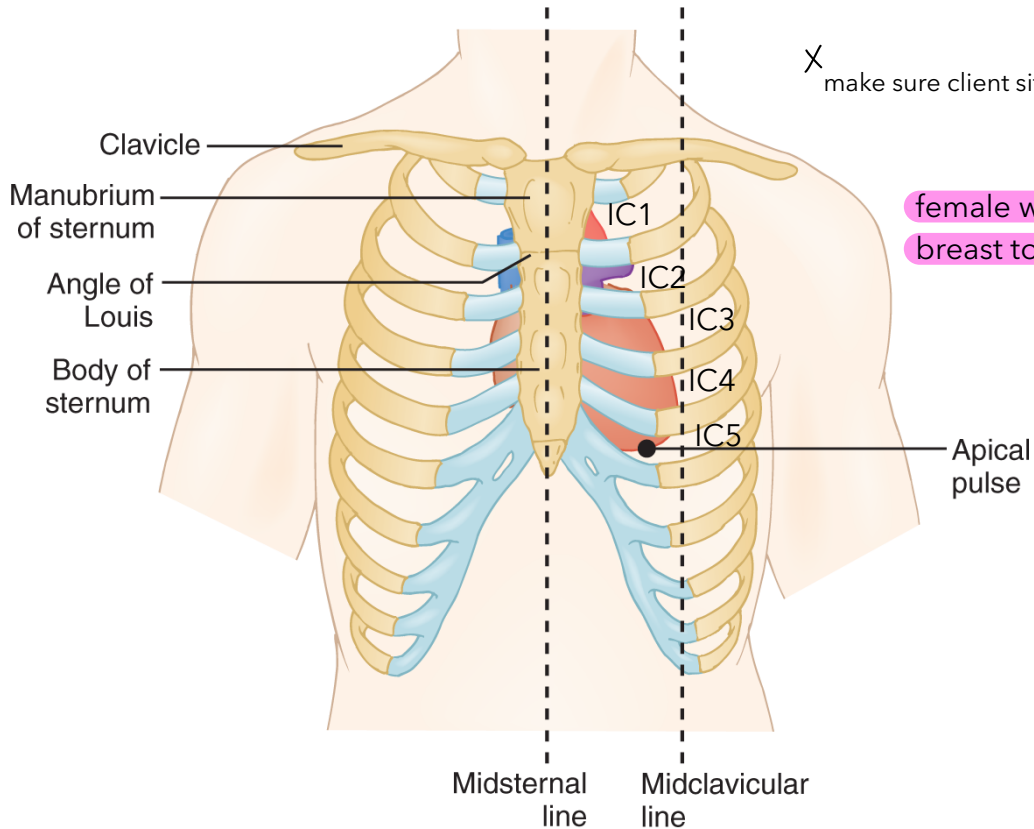
- Temporal-head
- Carotid-neck
- Apical-chest
- Brachial-arm
- Radial-wrist
- Femoral-thigh/groin
- Popliteal-knee
- Posterior Tibial-ankle
- Dorsalis Pedis-foot



Pulse Assessment

- If you can't feel a pulse, move up and assess one more proximal to the one you were trying to feel or use a Doppler to locate it.
- If pulse is irregular or this is your first time assessing, count for 1 full minute
- **Tachycardia is a pulse >100**
- **Bradycardia is a pulse <60**
- Always use fingers, not thumb to assess pulse
- Keep fingers in independent position when feeling for pulse so you don't accidentally mistake your pulse for the client's.

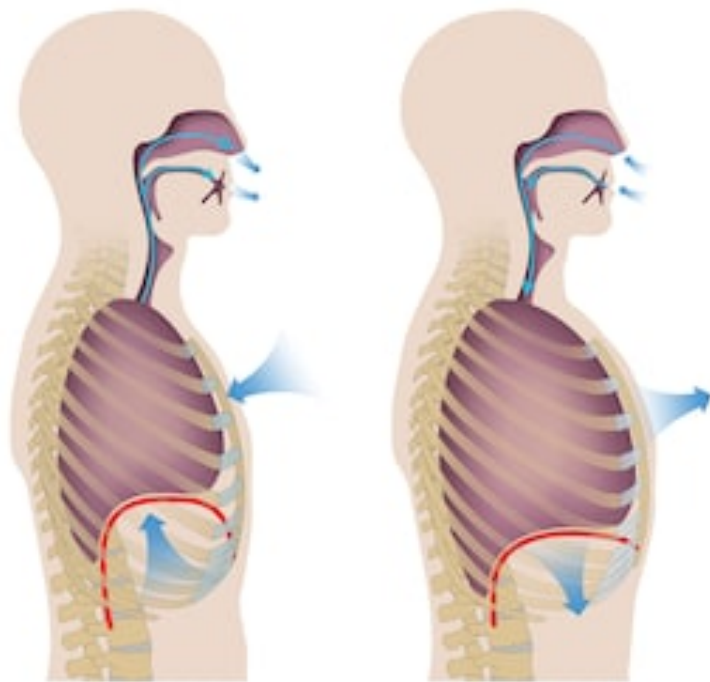




X make sure client sits up for locating the IC5.

female will need to lift their breast to find the apical pulse.

Respirations (12-20 BPM)



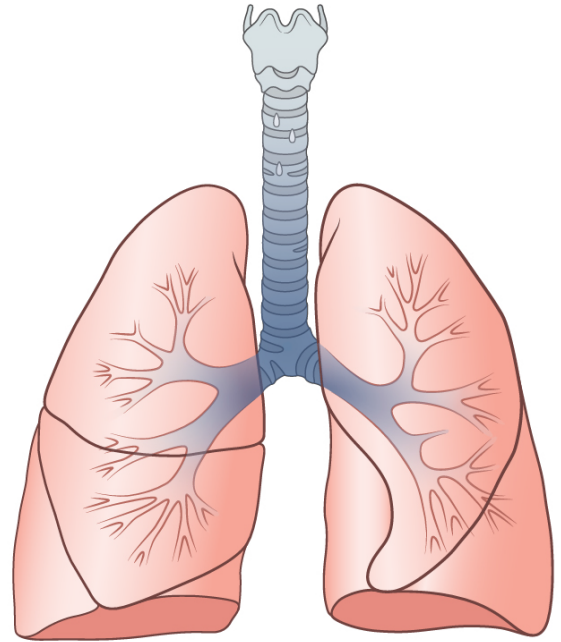
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Assessing Respirations

1. Rate
 - Recorded in breaths per minute
 - **Bradypnea=slow breathing**
 - **Tachypnea=fast breathing**
2. Depth
 - Deep vs Shallow
3. Rhythm
 - Regular vs Irregular
4. Quality
 - Labored vs unlabored
 - Any adventitious breath sounds
5. Effectiveness
 - Pulse ox reading
 - ABG's
 - HGB

Adventitious Breath Sounds & Abnormal Airway Findings

- **Stridor** (foreign body in the trachea)
 - **Rhonchi** (mucous build up)
 - **Wheeze** (inflammation)
 - **Crackles** (fluid build up)
 - **Friction rub** (lose of mucous fluid)
 - **Retractions**
 - **Grunting** (found in children and infants)
 - **Nasal Flaring** (found in children)
 - **Head Bobbing** (found in children)
- abnormal finding



Tripod Position

respiratory depression possibly

Tripod position suggests distress, resting weight on knees helps with chest expansion



Blood Pressure

SBP (90-120)/
DBP (60-80)

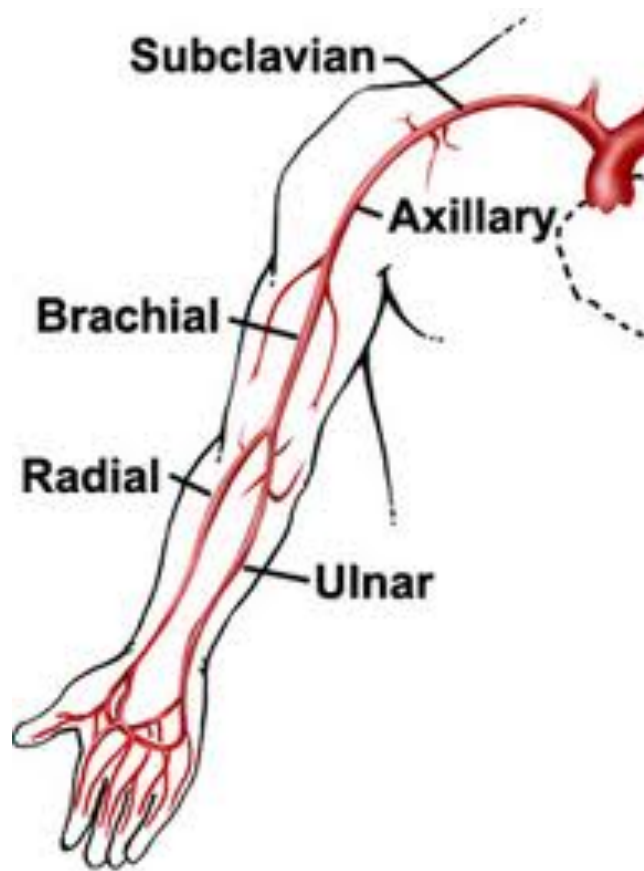


Factors Affecting BP

- **Age**- rises with age
- **Exercise**- increases CO and causes increase in BP
- **Stress**- Sympathetic nervous system increase CO and causes vasoconstriction which increase BP
- **Race**- African Americans have higher BP's
- **Sex**-after puberty females have lower BP's but after menopause they have higher
- **Medications**- caffeine increases BP
- **Obesity**-predisposes a person to increase BP
- **Diurnal variations**-BP lowest early in the morning, and highest late in the afternoon
- **Medical Conditions**-Heart Failure, atherosclerosis, valve issues, ventricle hypertrophy
- **Temperature**- vasodilation vs vasoconstriction

Assessing BP

- The bladder cuff is measured according to patient size, not age
 - If the cuff is too small, your reading will be falsely high
 - If the cuff is too big, your reading will be falsely low
 - Width should be 40% of arm circumference
 - Length should cover at least 2/3 of the limb circumference
- **Do not measure BP in the following areas:**
 - Shoulder, arm, or hand is injured
 - Cast or bulky bandage is on the limb
 - Surgical removal or breast or axillary lymph nodes on that side
 - IV infusion on that side
 - AV fistula for dialysis in that limb
- When taking a manual BP, **your systolic is the point at which your first hear a tapping sound, and your diastolic is the point at which sounds become inaudible**
- **Position client sitting with feet on the floor, legs uncrossed, elbow slightly flexed, palm facing up.**



Variations in BP

Hypertension

- BP above the normal limits for **at least 2 readings at 2 different times**
- HTN= systolic BP is higher than 140 or diastolic is higher than 90
- “Silent Killer”
 - **Only s/s sometimes is a headache**

Hypotension

- A systolic reading consistently between **85-110 in a adult whose normal pressure is higher than this**
- **Orthostatic Hypotension:** BP decreases when the client sits or stands as a result of peripheral vasodilation. Causes person to feel faint.

Blood Pressure Categories



BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120-129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130-139	or	80-89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

How to Assess for Orthostatic Hypotension

1. Lay the patient supine for 10min
2. Record BP **first asses.**
3. Assist the client to slowly sit and/or stand
4. Immediately recheck in the same site **second asses.**
5. Repeat the HR and BP after 3min **third assessment.**
6. Record the results. A drop in BP of **20 systolic** or **10 diastolic** indicates orthostatic hypotension

X
beta blockers and anti hypertensive drug can cause OH.

X
common finding in
the morning.

→ let the legs hang on
the edge of the bed.



Oxygen Saturation
(>95%)



Pulse Oximetry

- **Normal O2 sats are 95-100%**
- **Below 70% is life-threatening**
- Rotate signs of the **adhesive ones every 4 hrs** and the **spring-tension ones every 2hrs** to prevent tissue irritation
- May need to cover area with a blanket to prevent excessive light from interfering with the reading
- **Choose a warm finger or toe to get your reading**
- Factors Affecting the Reading:
 - Hemoglobin (low Hgb)
 - Circulation (poor circulation)
 - Activity (physical activity causing increase O2 demand)
 - CO poisoning (monoxide competing with O2)
 - Nail polish (alcohol interpretation)

X use forehead and earlobes for other sites with clients perfusion.

adhesive oximetry (long term purposes).



Pulse Oximeter Waveform



Normal Signal



Low Perfusion

excessive light and/or nail polish



Noise Artifact

equipment interferes



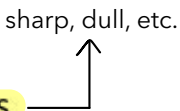
Motion Artifact



6th vital sign..... don't forget to ask and assess every time for pain.

Mnemonics for pain assessment

OLD CART

- O- Onset
- L- Location
- D- Duration
- **C- Characteristics**  sharp, dull, etc.
- A- Aggravating factors
- R- Radiation
- T- Treatment

PQRST

- P- Provoked
- Q- Quality
- R- Region/Radiation
- **Severity** pain scale (0-10)
- Timing

assessing pain
with pain scale
not asking them.

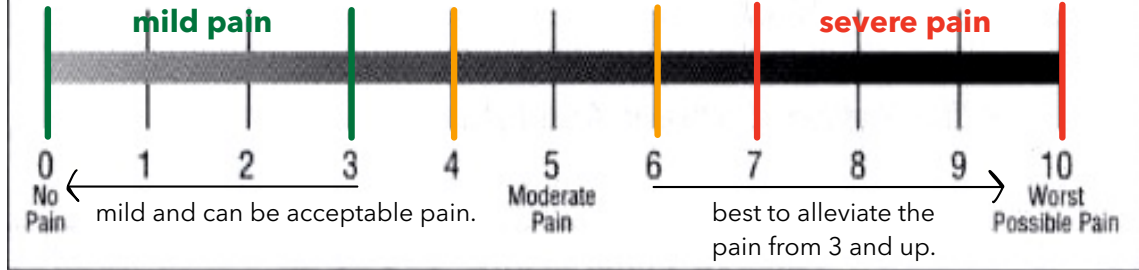
Pain Scales-Numeric

for all adulthood.

"on a scale of 0-10, what is your pain level?"

PAIN SCORE 0-10 NUMERICAL RATING

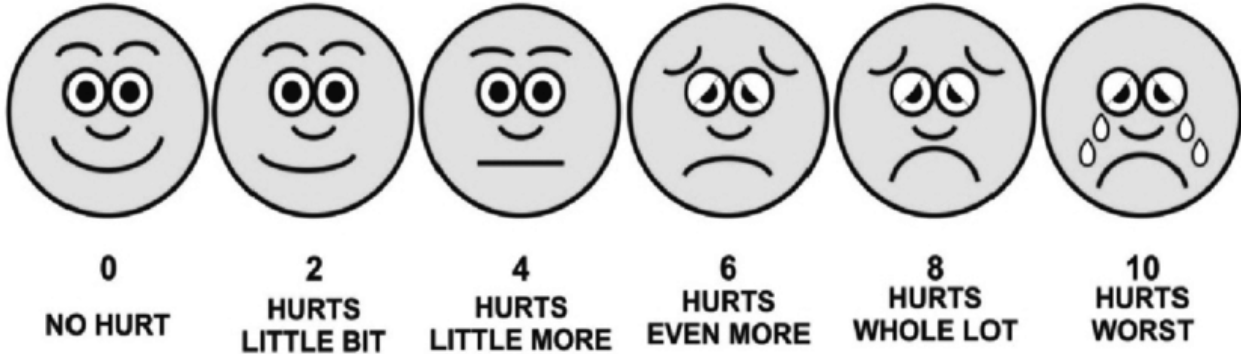
0-10 Numerical Rating Scale



truth the patient's
statement
because you not
know exactly it's
subjective data.

Pain Scales-Wong-Baker Faces

Show the picture and ask the patient what represent them as their pain?



Pain Scales-FLACC

Used for nonverbal and infants patients.

This scale is consider objective data.

	Scoring		
Categories	0	1	2
Face	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractable	Difficult to console or comfort

Pain Scales-NIPS

younger than 2 months
(objective data)

Neonatal Infant Pain Scale (NIPS)

Variable	Finding	Points
Facial expression	Relaxed (Restful face, neutral expression)	0
	Grimace (Tight facial muscles. Furrowed brow, chin, jaw)	1
Cry	No cry (Quiet, not crying)	0
	Whimper (Mild moaning, intermittent)	1
	Vigorous crying (loud scream, shrill, continuous). If Infant is intubated, score silent cry based on facial movement.	2
Breathing pattern	Relaxed (Usual pattern for this infant)	0
	Change in breathing (Irregular, faster than usual, gagging, breath holding)	1
Arms	Relaxed (No muscular rigidity, occasional random movements of arms)	0
	Flexed/extended (Tense, straight arms, rigid and/or rapid extension, flexion)	1
Legs	Relaxed (No muscular rigidity, occasional random movements)	0
	Flexed/Extended (Tense, Straight legs, rigid and/or rapid extension, flexion)	1
State of Arousal	Sleeping/Awake (Quiet, peaceful, sleeping or alert and settled)	0
	Fussy (Alert, restless and thrashing)	1
Heart Rate	Within 10% of baseline	0
	11-20% of baseline	1
	>20% of baseline	2
O₂ Saturation	No additional O ₂ needed to maintain O ₂ saturation	0
	Additional O ₂ required to maintain O ₂ saturation	1

Limitations: A falsely low score may be seen in an infant who is too ill to respond or who is receiving a paralyzing agent.

(A score greater than 3 indicates pain)