Care Homes and Domiciliary Care

NHS Vale of York Clinical Commissioning Group

Taking a Manual Pulse, Blood Pressure, Temperature & Respiration rate

Disclaimer –

This workbook is to be used in conjunction with a practical training session.

This workbook is designed to be supported by the Vale of York CCG care homes team. If used outside the Vale of York locality it may not be as beneficial when support is not accessed. It is the sole responsibility of the care home or care agency manager and their organisation to ensure their staff are confident and competent to carry out clinical observations. This workbook and any parts contained therein including any of the tools must not be changed, amended or reproduced. The workbook or any part including the tools cannot be sold or training delivered for monetary gain. The training is to be used in individual homes or care agencies and training must not be delivered to any others outside the organisation for which it has been intended. This workbook must not be shared on social media or any websites. This workbook remains the property of the Vale of York CCG.

Reviewed and updated 25/01/2021

This workbook is a free resource that supports the practical procedure of taking specific observations. Residents may need to have observations taken for a variety of reasons and this workbook is to be used in conjunction with a practical teaching session and competency assessment.

Do not undertake or attempt these or any other procedure unless you are, or have supervision from, a properly trained, experienced and competent person.

This workbook is broken down in sections:

1. **Why we may need to take clinical observations**
2. **The 'procedural umbrella'**
3. **Underpinning knowledge of**
    - **Temperature**
    - **Pulse**
    - **Respiration**
    - **Blood pressure**
4. **Recording and reporting**
5. **Competency – Classroom competent and Self assessment**

Some sections will have short tasks to be completed and will be indicated by

when reading and understanding is needed

thinking about or discussion

writing e.g practice completing a form

finding out further information

practical hands on session will take place

The workbook will take approximately 60 – 90 minutes to go through alongside the practical session.

This workbook is to supplement the procedural training and act as a reference guide during and following the training undertaken.

Depending on where you work and the nature of your role, you may take clinical measurements from residents occasionally, this may be part of a routine health check , as a request from a health professional such as a GP. It is therefore essential that you understand the principles of

- **Why** you're doing an observation.
- **When** to do it.
- **How** to do it.
- **What** your findings might mean for the resident
- **Where** to report and record your findings.

The care worker is responsible for the maintenance of their competence at all times and ensure it is always currant and access further training as required.

Any procedures should be undertaken in line with your organisations policies and procedures and it is the care workers' responsibility to familiarise themselves with these.

The procedural umbrella highlights everything the individual must take into account when undertaking basic clinical observations. (Needham and Sunderland 2013)

- **Accountability**
- **Consent**
- **Local policy and guidance**
- **Infection prevention and control measures – cleaning of equipment, hand hygiene and use of PPE**
- **Equipment maintenance**
- **Record keeping**
- **Reporting findings**

Equipment maintenance

Routine maintenance by the user ensures that the device continues to function correctly.

It entails regular inspection and care, as recommended in the manufacturer's user information

This should clearly show the routine tasks and how they should be carried out.

These will include:

Checking that it is working correctly before use
Regular cleaning
Specific daily/weekly checks
Noting when it has stopped working or when obvious damage has occurred, and then discontinuing use
Contacting the relevant servicing organisation
Any problems the user finds can then be referred to a repair service.

(MHRA 2006)

Find out how to maintain your equipment & how to record checks & what to do if things go wrong.

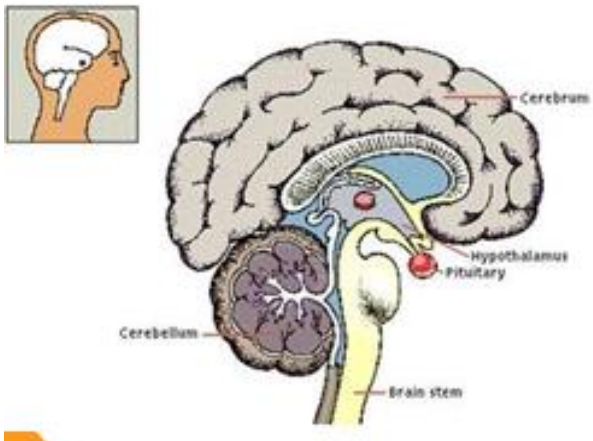
Temperature

Key points

- **One of 4 vital signs**
- **Must be recorded with precision, consistency and diligence**
- **Must be measured accurately as it has an impact on diagnosis and treatment**
- **Inaccurate temperature measurement may compromise patient safety**
  www.nursingtimes.net accessed 2020

How is temperature controlled in the body?

Core body temperature is set and regulated by the hypothalamus and a relatively constant temperature is maintained by homeostasis which is the constant process of heat gain and heat loss.

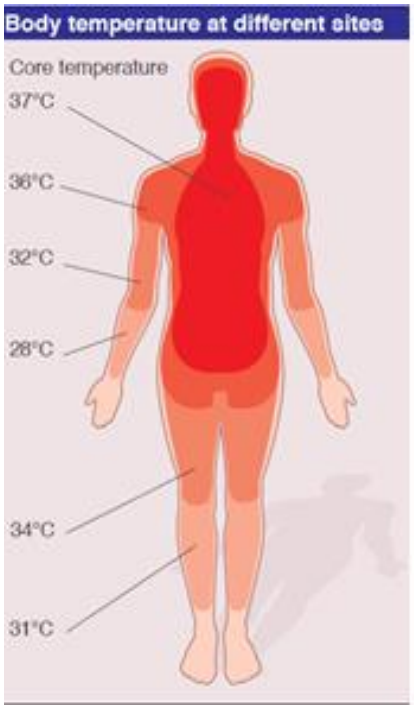


Royal Marsden 2008

Why do we take a residents temperature?

- To obtain a the baseline temperature which allows comparisons to be made with future recording
- To enable close observation in resolving hypothermia/hyperthermia
- To observe and monitor patients for changes indicating an infection

Think of any other reasons



Body temperature varies according to:

- Time of day

(lower in early hours of the morning)

- Age
- Hormonal factors
- The environment
- Exercise
- Smoking
- Chewing
- Hot drinks
- Where you take it

Hatchett 2012

- In evening ⬆
- In early hours of morning ⬇
- Age Young and older inability to maintain equilibrium
- Exercise ▲ Body temperature
- Thyroid hormones ▲ Metabolic rate therefore... ▲ Body temperature

With these changes it is important to record and report what time the temperature was taken.

Think how and where you will record a resident's temperature , do you remember to include the time it was taken?

Get your thermometer , ensure it is working correctly and make sure you know when and how it is being maintained in preparation for the practical session.

- We will now complete the practical session of taking a temperature

 Where and how will these readings be recorded ?

 Think about what these readings may mean and how they are to be reported and to whom

What is a high temperature?
Normal body temperature is different for everyone and changes during the day.
A high temperature is usually considered to be 38C or above. This is sometimes called a fever.
Many things can cause a high temperature, but it's usually caused by your body fighting an infection.
Check for a high temperature
You may have a high temperature if:

- your chest or back feel hotter than usual
- you have other symptoms, such as shivering (chills), sweating or warm, red skin
- a thermometer says your temperature is 38C or above

If a resident feels hot or shivery, they may have a high temperature even if a thermometer says their temperature is below 38C.

NHSonline accessed2020

Normal	36.8˚C (+/-0.7˚C)
Low Grade Pyrexia	Up to 38˚C
Moderate to High Grade Pyrexia	38˚C to 40˚C
High Grade or Critical Pyrexia	40˚C + (*LIFE THREATENING*)
Hypothermia	Below 35˚C

Pyrexia is a raised temperature or a fever.

Hypothermia is a dangerous drop in body temperature below 35C (normal body temperature is around 37C). It's a medical emergency that needs to be treated in hospital. NHSonline.accessed 2020

Signs of hypothermia include

•shivering

•pale, cold and dry skin – their skin and lips may be blue

•slurred speech

•slow breathing

•tiredness or confusion

 Think about what causes hypothermia

•do not wear enough clothes in cold weather

•stay out in the cold too long

•fall into cold water

•have wet clothes and get cold

•live in a cold house – older people living alone are particularly at risk

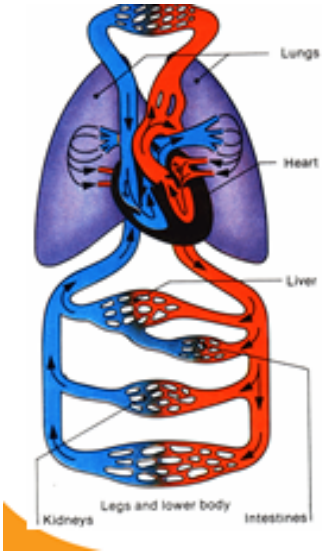
NHS.net accessed 2020

Pulse

Key points

- **Normal pulse rate in adults is between 60-100 beats per minute**
- **Pulse rate in babies is higher**
- **The rhythm of pulse should be regular and consistent**
- **Any deviation from normal pulse rate for the resident should be reported and investigated**
- **Pulse rates should be accurately documented**

Overview of the cardio vascular system



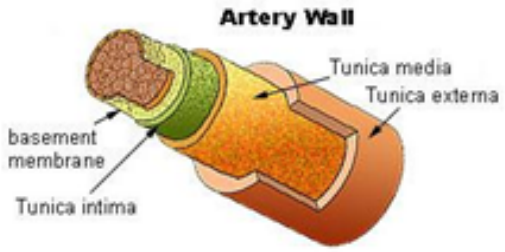
- The left side of the heart pumps oxygenated blood to the body and brain
- The right side of the heart pumps deoxygenated blood to the lungs
- Arteries carry oxygenated blood away from the heart to tissues in the body
- Veins carry deoxygenated blood from the body to the heart

Hatchett 2012

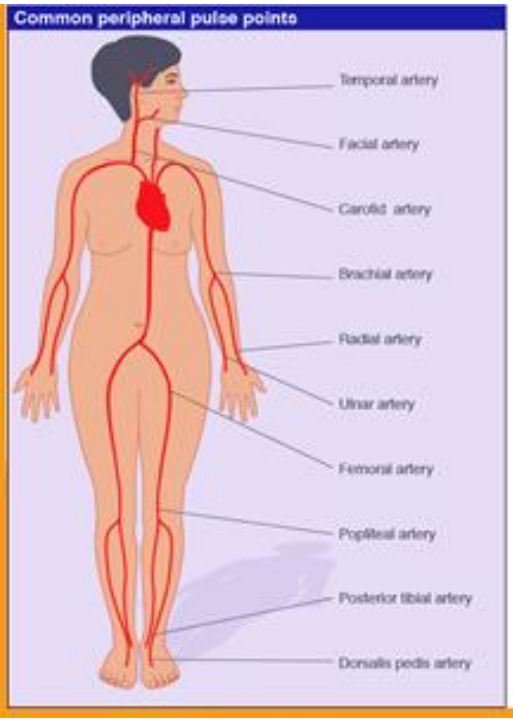
What is a pulse?

"The pulse is a pressure wave in the arterial wall. If an artery wall is pressed at a pulse point, the pulse of pressure in the arterial wall can be felt as blood is squeezed along with each contraction of the heart. The pulse, therefore, occurs with each heartbeat; the frequency, or rate, at which it is felt indicates the rate at which the heart is beating (the heart rate). The strength (or amplitude) of the pulse depends on the volume of blood squeezed out of the heart with each beat; this is called the stroke volume. The strength of the pulse is also influenced by the extent of elasticity of the artery wall. The arteries become stiffer with age – this is called arteriosclerosis – and the extent to which they can stretch with each pulse reduces"

Nursingtimes.net accessed2020.



- **Arteries are made up of 3 elastic layers and a hollow core (lumen)**
- **As blood is pushed out of the heart into the lumen of the arteries a pressure wave is created**
- **This stretches the elastic walls of the artery creating a pulse**



Points in the body where a pulse can be found


Have a go at feeling your own pulse

A pulse can be felt in arteries that lie near the surface

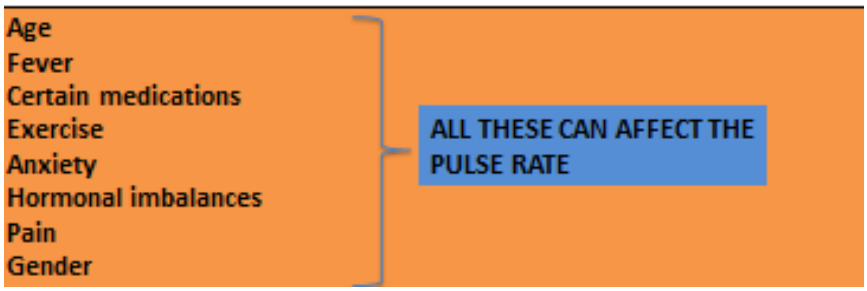
By pressing the artery against firm tissue, such as bone, you can feel the pulse

The pulse rate is the same as the heart rate

A normal heart rate of an adult is between 60-90 beats per minute

Royal Marsden online accessed2018

Think about what might affect the pulse rate and how difficult it might be to take the pulse of some of your residents



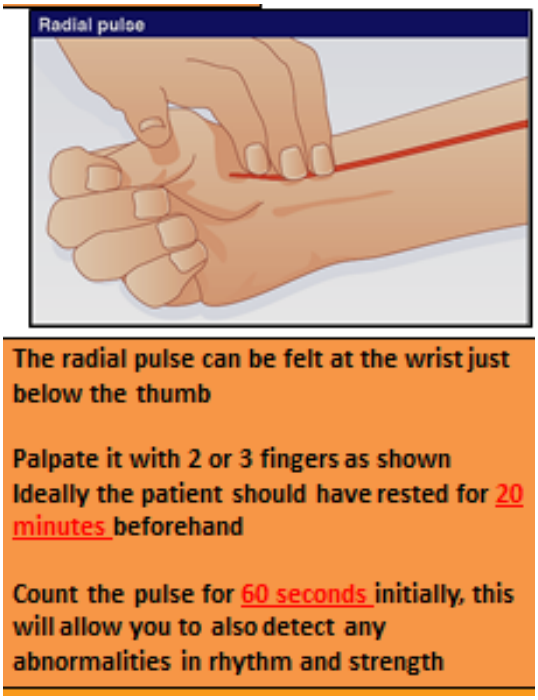
We will now complete the practical session on how to take a pulse – you will need a watch with a second hand

If we are to take the pulse of a colleague – what implications does this have?

Radial pulse

- To find the radial pulse, trace the thumb to its base and to where the radial bone begins at the wrist.
- Applying excess or insufficient pressure will make it difficult to feel the pulse; the ideal pressure is equal to the weight of the hand and wrist, which will happen automatically when the correct position is adopted and the pulse felt for.
- To achieve the correct position, place two fingertips directly alongside the radial styloid, just to the inside
- Turn the patient's hand over to allow it to hang from your fingertips. Ensure the patient's arm is relaxed, so you are supporting the weight of hand and wrist on your fingertips.
- If the patient has cold hands a radial pulse may be difficult to palpate because of reduced peripheral circulation.
- Similarly, if blood pressure is very low, the peripheral circulation will be compromised.
- Nursingtimes.net accessed 2020

What are we looking for when we take a pulse?



Hatchett 2012

Remember

- Identify key anatomical sites where can the pulse be felt – this makes it easier to access sites and maximises the potential for a safe assessment
- Obtain informed consent
- Ensure the resident is relaxed and the relative position of the chosen site is equal to, or lower than, the level of the heart
- When assessing a patient's pulse, the following must always be documented:
  - Time
  - Pulse rate
  - Pulse quality

How are we going to record and report the pulse rate? Think SBAR

- A normal adult pulse will beat regularly between 60 and 100 times each minute at rest
- Pulses are usually easily palpable
- Residents with a weak or unstable pulse should be assessed further; weak pulses indicate reduced cardiac output and can progress to deterioration, for example fainting, or perhaps a more serious problem.
- The rhythm of the pulses should be regular and consistent; unstable or irregular pulses indicate irregular contractions of the heart
- A strong, bounding pulse indicates high blood pressure.
- Pain, stress or exertion will increase the pulse rate, but it should return to normal when the underlying trigger is abated.

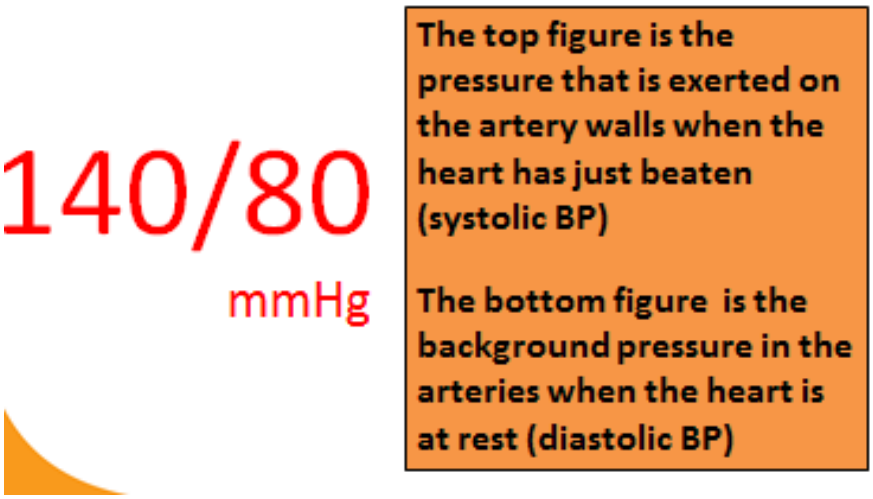
- A slower-than-normal pulse can result from some medications, for example digoxin and beta-blockers, and may also be present in people who are accustomed to strenuous activity. Nursingtimes.net accessed 2020

Blood Pressure

What is blood pressure ?

- The pressure of blood against the walls of the main arteries
- Hypertension – high blood pressure: consistently >140/90mmHg
- Hypotension - Low blood pressure: typically a systolic reading of <90mmHg

National Institute for Health and Care Excellence (2019); McFerran and Martin (2017)



Why would you take residents blood pressure?

- To have a baseline recording & To establish if a resident has high or low blood pressure
- Monitor BP or other health conditions
- Change in health status / Change in medication

- As part of a general health check
- Falls

Things that can affect a person's BP

Emotional state / stress	Exercise	Smoking
Temperature Respiration	Age (over 65	Low blood pressure at night
Bladder distension	Eating	Alcohol use
Pain	Race / ethnicity	Sudden changes in posture
White coat hypertension	Underlying conditions Diabetes , renal failure	Overweight
Too much salt & not enough fruit and veg	Lack of sleep / disturbed sleep	NHS.net accessed 2020 Nursingtimes.net accessed 2020

A bit about equipment

It is important to note that some automated BP measurement devices are unreliable in patients with cardiac arrhythmia, such as atrial fibrillation (AF) this is because the pulse pressures can vary significantly with each pulse. (National Institute for Health and Care Excellence, 2019). It is important to know if your resident is diagnosed with this condition that a health professional may need to take the residents' BP to get an accurate manual reading.

Remember to maintain the equipment in good working order and to adhere to strict IPC cleaning of the equipment after and before use. PPE should be worn according to current guidelines when carrying out a BP on a resident.

All BP measuring equipment should be regularly checked and calibrated in accordance with the manufacturer's instructions (MHRA, 2019). Cuffs and their hoses should be regularly inspected and replaced as necessary; excessive air leakage from damaged cuffs, hoses and tubing connectors may reduce the accuracy of the readings. If reusable cuffs are used, they should be cleaned between patients in accordance with the manufacturer's instructions, ensuring that cleaning fluid does not enter the cuff bladder or hoses. Faulty devices can lead to inaccurate BP

measurements, with significant effects on patient care. Healthcare providers have a responsibility to ensure adequate maintenance arrangements are in place (MHRA, 2019).

 Find out where and how your equipment is checked and maintained and how this is recorded.

Errors when measuring a BP

- Patient not being rested and relaxed when BP is measured
- Defective equipment – for example, leaky tubing or a faulty valve
- Use of incorrectly sized cuff
- Cuff not being on a level with the heart
- Poor technique;
- 'Digit preference' – rounding a reading up to the nearest 5mmHg or 10mmHg;
- Observer bias – for example, expecting a young patient's BP to be normal / Irregular pulse
  (MHRA, 2019; O'Brien, 2015).

 We will now carry out the practical session on how to take a Blood Pressure

This procedure should be undertaken only after approved training, supervised practice and competency assessment, and carried out in accordance with local policies and protocols.

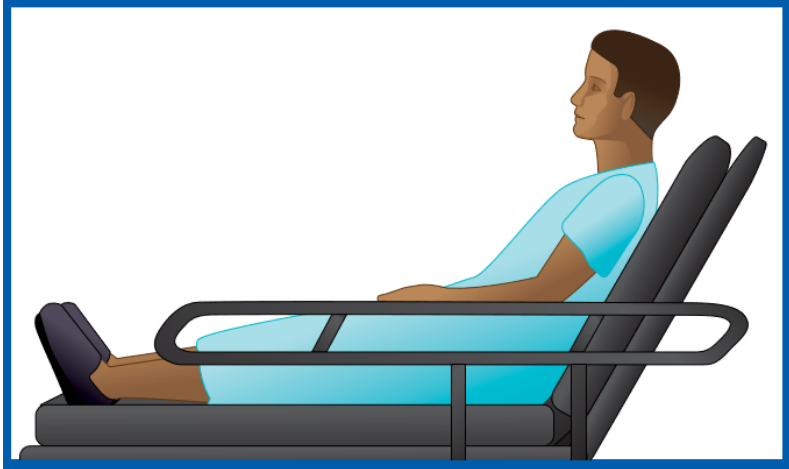
You will need your BP machine, the correct cuff size for the resident, cleaning materials as recommended by the machine manufacturer and a set of PPE.

Preparation

Before undertaking an automated BP measurement,

- Ensure the resident is either lying on a bed or sitting comfortably in a chair that has a backrest, and positioned with feet placed on the floor and legs uncrossed
- Ideally, the resident should not have drunk alcohol or a caffeinated drink or smoked tobacco for 15 minutes before the procedure, and should be relaxed, not talking and should have been in position for at least five minutes (British and Irish Hypertension Society, 2017a)
- Explain the procedure to the resident and obtain consent. Ensure there are no contraindications to using their arm such as lymphodema, recent trauma or surgery, or are having renal dialysis that entails a cannula into their arm. If there are problems, use the other arm
- Remove any tight clothing that is restricting the arm, and support it at the level of the heart using a pillow, table or arm rest
- Ensure the resident is sitting comfortably

Fig 1. **Correct patient position for BP measurement**



1a. When on a bed or trolley, enure the patient is sitting, with legs outstretched and uncrossed

1b. When seated, ensure the patient is in a chair with a backrest and positioned with feet on the floor and legs uncrossed

Nursingtimes.net accessed 2020

Fig 2. **Arm support**

Use a pillow, armrest or table to support the patient's arm at heart level

Nursingtimes.net accessed 2020

- Wash your hands and follow local protocols on PPE
- Check the equipment ensuring it is in good working order and that it has been serviced and calibrated. The date of next annual servicing should be clearly marked on the sphygmomanometer. Ensure the manufacturer's operating instructions are followed.
- Check the pulse: if it is irregular, it may be necessary to use a manual BP measurement device and refer back to your health professional
- Select an appropriately sized cuff, as recommended by the manufacturer: the inflatable bladder cuff should encircle at least 80% of the arm but not more than 100% of it.
- Place the cuff snugly and neatly onto the patient's arm, 2cm above the brachial artery and aligning the brachial artery indicator on the cuff with the brachial artery
- Follow instructions - Switch on the automated BP device and press start to record the BP, following the manufacturer's recommendations.
- When the reading has registered, document the systolic and diastolic BP measurements on the residents observation chart, following local protocols, escalate if necessary using SBAR
- Switch off the automated device and remove the cuff.
- Follow current PPE guidelines for care staff and equipment cleaning

Nursingtimes.net accessed 2020

Lying and standing/ sitting BP – do not undertake this procedure if you do not feel competent to do so. This procedure will require 2 members of care staff to ensure resident safety.

This is the routine measurement of both lying and standing BP is recommended in patients aged ≥65 years and those with diabetes or symptoms that suggest they may have postural hypotension; this is because these individuals can experience a significant fall in BP when standing up (NICE, 2019; NICE, 2013). Before starting, ascertain whether you will need assistance from a colleague to help the resident to stand. Explain the procedure to the resident and obtain consent. Ideally, a manual BP measurement device should be used.

1. Perform the first measurement with the resident lying down, following the procedure described above.

2. Leaving the cuff in place, ask the resident to stand up. Residents with postural hypotension may feel dizzy and lightheaded so it is important to be alert to this possibility and to ensure that the resident safety is maintained.

3. Allow the resident to stand for one minute.

4 Ensure the residents arm is supported at the level of the heart

5. Repeat the BP measurement, taking particular care to make sure the arm continues to be well supported (Beevers et al, 2015). See fig below

6. After the resident has been standing for three minutes, repeat the BP measurement.

7. Throughout the procedure, observe and document any signs or symptoms of postural hypotension, including dizziness, lightheadedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations. If this happens stop taking the BP and lay or sit the resident down and stay with them until they are fully recovered, do not undertake the procedure again and inform your health professional

8. Make sure the resident is made comfortable after the procedure

9. Record and report both readings

10. follow cleaning and PPE guidelines

Nursingtimes.net accessed 2020

Think about the importance of accurate recording and reporting & how will you do this

Practice filling in the SBAR and include a residents BP recordings

Consequences of hypertension (high blood pressure) and hypotension (low blood pressure)

High blood pressure can lead to heart attack and stroke, vascular dementia, kidney disease and heart failure and low blood pressure can lead to dizziness, confusion, weakness, fainting, blurred vision, nausea light headed ness and falls,. NHS.net accessed 2020.

think about what causes hypertension and hypotension and might be done for residents with these conditions.

Respiratory Rates

What does this mean ?

“Respiratory rate (RR), or the number of breaths per minute, is a clinical sign that represents ventilation (the movement of air in and out of the lungs). A change in RR is often the first sign of deterioration as the body attempts to maintain oxygen delivery to the tissues.

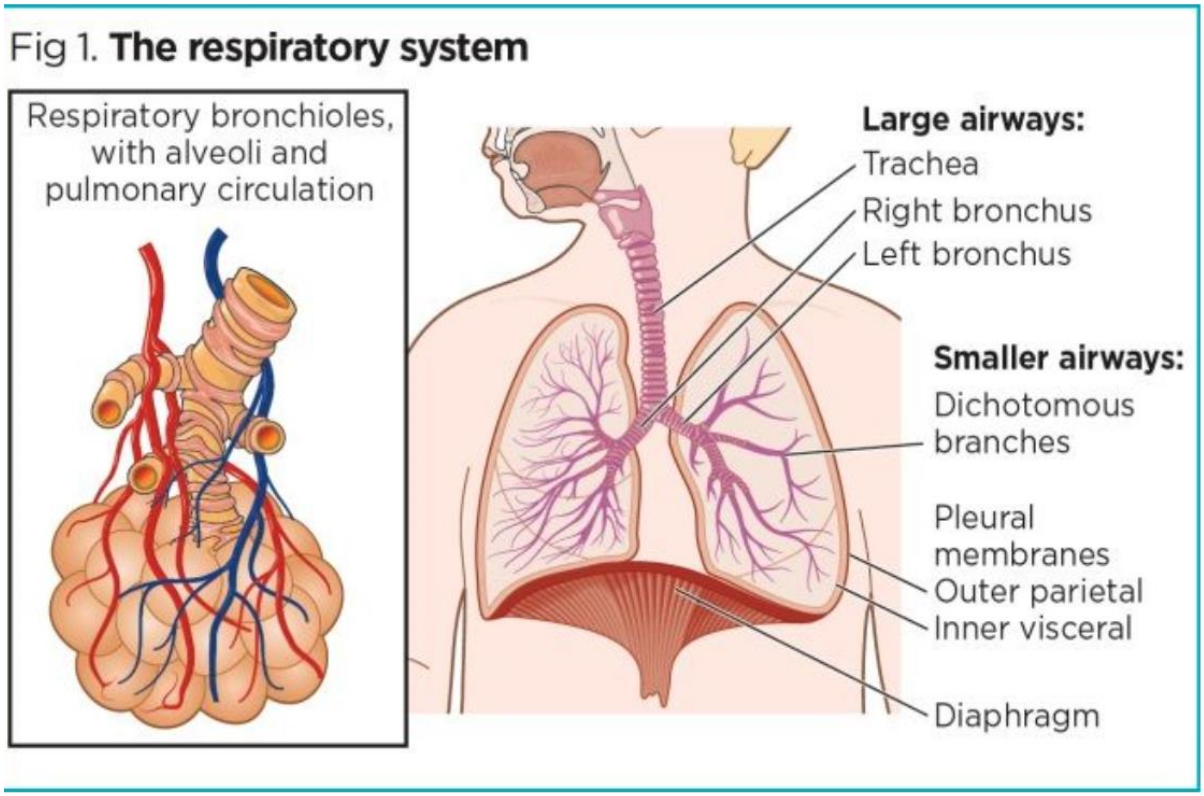
Failing to recognise the early signs of deterioration can result in poor outcomes for patients” Nursing times.net. accessed 2020

Think about what this means for your residents

Measuring RR is can sometimes be difficult and is often not performed accurately, sometimes due to lack of time and due to not understanding why this is important, ,yet this observation can be the first detection of deterioration. (Dougherty and Lister, 2015).

Breathing is something we all so but do you understand how the lungs work?

Look at the diagram to familiarise yourself with the anatomy of the respiratory system



- **The respiratory system allow us to breath in oxygen, which is used by cells throughout the body to create energy**
- **A by-product of this energy production is carbon dioxide which has to be eliminated by the body quickly - this is done when we breathe out**

Inspiration is breathing in expiration is breathing out. To measure the RR the movement of the chest is observed. This can change due to

- Exercise
- Sleep
- Anxiety

But will return to a normal rate when a person is in a normal relaxed state.

A baseline RR at rest can be maintained at 12 -20 breaths per minute, breathing should be noiseless and effortless.

 What could cause a resident to breath faster or slower?- Some of these you may not have heard of or will ever come across

Tachypnoea breathing fast – a high RR			Bradypnoea – breathing very slow – low RR
anxiety	asthma	Shock	Opioid overdose
Emotional distress	Pulmonary embolism	COPD	Diabetic coma
pain	pnemonia	Diabetic ketoacidosis	Exhaustion caused by severe airway obstruction
fever	Respiratory distress		Sleep apnoea
exercise	Herat failure		Obesity hypoventilation syndrome

When would you take and monitor a residents RR?

- To get baseline information
- To observe and recognise signs of deterioration
- Monitor chronic lung disease
- Evaluating treatment
- Monitoring oxygen levels if a resident is on oxygen

 We will now carry out the practical procedure of observing a RR, you will need a watch with a second hand.

This can be carried out after taking a pulse while the resident is still sitting or laying in a relaxed and comfortable position.

1. Follow IPC guidelines
2. Explain procedure and the residents consent
3. Position the patient in a comfortable position. Maintain a constant temperature to prevent shivering, which can increase RR. If possible, remove bulky clothing or bed covers from the upper part of the patient's body to facilitate counting RR and
    1. observing depth, is breathing shallow
    2. is breathing gasping or whistling

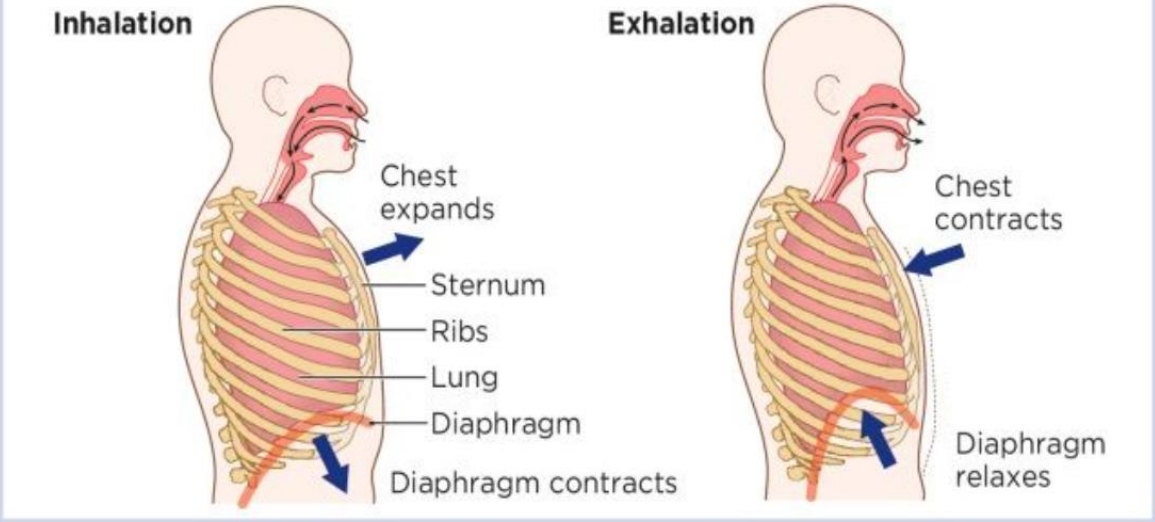
3. is there noises, rattling, gurgling or coughing
4. what is the regularity and pattern of breathing for this resident- is it even and steady
5. is it painful for the resident when breathing in or out

If the patient is sitting, their feet must be flat on the floor; sitting with legs suspended can reduce venous return, which may increase heart rate and subsequently RR.

4. If a patient has been prescribed oxygen, ensure the oxygen mask or nasal cannula is correctly positioned and recorded on the observation chart before recording RR.
5. Allow the patient to rest, if possible, for 20 minutes before taking the measurement. RR may increase after activity, giving an abnormal baseline. Some medication can affect RR so this should also be taken into consideration.
6. While you are preparing the patient, observe their respiratory function, for example, whether they can talk in full sentences (Dougherty and Lister, 2015). Taking a breath mid-sentence or one-word answers may be a sign of respiratory distress.
7. Note whether the patient is alert and orientated to time and place (Dougherty and Lister, 2015). Changes in cognitive status, such as confusion, may be due to hypoxia, cerebral injury or side-effects of medication, such as opiates.
8. Using a watch with a second hand, count breaths (number of times the chest moves up and down) for a full minute. This length of time is needed as changes can occur in the respiratory pattern and rate.
9. While observing the RR, note the rhythm, which may indicate signs of underlying illness. Respirations should be regular with equal pause between each breath Observe the patient's lips for signs of cyanosis (blue tinge), which may indicate hypoxia (low oxygen saturation [SpO2]).
10. Document and report RR – remember to use the SBAR
11. Check your resident is comfortable and follow IPC procedures

Adapted from Nursing times.net accessed 2020

Fig 1. **Chest movements with inhalation and exhalation**



Nursing times.net accessed 2020

Pulse Oximetry

All homes will have a pulse oximeter and here is a link demonstrating how to use

https://www.youtube.com/watch?v=QabKghrtXps

As with all equipment you need to follow the manufacturers instructions for use, maintenance and cleaning, for example - after each patient the pulse oximeter should be cleaned externally with an alcohol wipe.

Initially, we would suggest that you use the pulse oximeter when you need to speak to a health care professional about a resident. This information, plus other observations will help to guide the need for further assessment.

If you do carry out these clinical observations you need to add this information to the STOP and WATCH assessment and SBAR communication form as this crucial information will help decide treatment and care for the resident

It is not recommend that you perform routine pulse oximeter checks, but only as a way of assessing someone you are concerned about already and want to call for help.

Most fit adults have a value over 95%, but for some of your residents a value as low as 90% may be ‘normal’ for them.

What is a pulse oximeter?

A pulse oximeter measures the level of oxygen in the blood. It can also measure the speed that the heart is beating/pulse rate

How to use a pulse oximeter

It is important to use the pulse oximeter as instructed to get an accurate reading.

- Remove any nail polish or false nails (false nails or nail varnish can affect how the oximeter works).
- Make sure the person tested has been sitting down for at least five minutes before taking the measurement.
- Warm the hand if it is cold.
- Switch the pulse oximeter on and place it on the middle or index finger (see diagram).

- Rest the hand in the middle of the chest and hold still for at least one minute or longer if the reading keeps changing.
- Record the result once the reading has not changed for five seconds.

What the readings mean

An ideal blood oxygen level is between 95% and 100%

An ideal heart rate/pulse is between 50 and 90 beats per minute (bpm).

Blood oxygen level	What you should do
95% and above	Continue to monitor three times a day
93% and 94%	Check again over the next hour making sure that hands are warm, and the probe is place correctly. If persistently within the amber range • **In hours call the GP** • **Out of Hours call VOCARE; 0300 123 2937**
92% and below	Check again and if persistently 92% or less to call 999

- If otherwise feeling well, but the blood oxygen is below 95%, rest for a further 5 minutes and repeat the measurement.
- If it is still below 95% follow the instructions in the table above.

People with darker skin

There is evidence that pulse oximeters may underestimate blood oxygen levels in individuals with darker skin - a baseline oxygen saturation should be taken when first assessing SpO2 rates and any changes in readings then compared to this baseline.

Competency

It is important that you feel confident and competent when you carry out any procedure, if you do not feel confident you must not carry out any procedure and report to you senior or manager so another staff member can do so providing they are trained and competent.

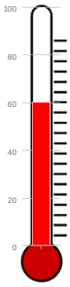
The procedures in the workbook are often called vital signs because we all need them to live and if a resident deteriorates these measurements of pulse, BP, temperature and respiration rate can be an early indication of something not being right. Alongside these measurements you should still need to complete the Stop and Watch and the SBAR and relay this important information to your health professional. Do not delay in passing on this information – it is not for the care worker to interpret the findings. You can send this information to the GP or other health professional by secure nhs.net email. The readings should also be discussed during handover , huddles and flash / priority meetings and at actual or virtual consultation.

Assessing competency in a training environment.

During the training session you will have had opportunity to practice these skills and for the trainer to assess you. For you to be assessed as 'classroom competent' you must have achieved the following competency checklist.

Once you have been assessed as 'classroom competent' you will still need to ensure you feel confident and competent within the care setting – if you do not you must not carry out these procedures. It is your responsibility to ensure that you are safe to carry out any aspects of care.

Use the competency checklist when you are carrying out these procedures with residents to ensure you are safe.


Competency

Pulse	Confident Yes	No	Respiratory Rate	Confident Yes	No
Knows where pulse sites are			Understands why RR is measured		
Locates brachial pulse			Takes RR for 60 seconds		
Demonstrate how brachial pulse for 60 seconds			Can describe rate, rhythm & depth of breathing		
Can describe, rate, quality & rhythm of pulse			Knows how & where to record findings		
Knows how & where to record findings			Knows where & how to report findings		
Knows where & how to report findings					
BP	**Confident Yes**	**No**	**Temperature**	**Confident Yes**	**No**
Knows how to check , maintain & clean equipment			Knows how to check , maintain & clean equipment		
Understands when a BP would be taken			Understands why & when a temperature would be taken		
Understands the limits of taking an automated BP			Can describe the implications & differences of a low & high temperature		
Demonstrates taking a BP			Knows how & where to record findings		
Knows how & where to record findings			Knows where & how to report findings		
Knows where & how to report findings					

Pulse Oximetry	Confident	
	Yes	No
Knows how to check , maintain & clean equipment		
Understands when an oxygen level would be taken		
Understands the limits of taking an automated BP		
Demonstrates using the pulse oximeter		
Knows how & where to record findings		
Knows where & how to report findings		

Name of Trainee		**Name of Trainer**	
Signature of Trainee		**Signature of Trainer**	
Date		**Date**	
Feedback Notes			

References:

Hatchett, R, (2012), Blood pressure part 2: procedure (using an aneroid sphygmomanometer), available at www.clinicalskills.net, accessed 29th September 2013.

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Needham, F, Sunderland, A, (2013), 'Basic clinical observations for health care support workers', power point presentation. Leeds Metropolitan University: Faculty of Health Sciences.

Links and for more information

Links

https://www.gov.uk/coronavirus

For more information and advice on the workbook, documents and training please contact

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