Assessing Arterial Blood Pressure

NAME:	S	U	NP	Comments
Assessment				
1. Identified patient using at least two identifiers.	___	___	___	___
2. Reviewed patient's EHR to assess for risk factors for blood pressure alterations.	___	___	___	___
3. Assessed patient's or family caregiver's literacy.	___	___	___	___
4. Assessed for factors that influence BP.	___	___	___	___
5. Determined previous baseline BP and site (when available) from patient's record. Determined any report of latex allergy.	___	___	___	___
6. Performed hand hygiene.	___	___	___	___
7. Assessed for factors that influence blood pressure measurement.	___	___	___	___
8. Assessed for signs and symptoms of BP alterations.	___	___	___	___
9. Assessed patient's knowledge, prior experience with BP measurement, and feelings about procedure.	___	___	___	___

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10. Assessed patient's goals or preferences for how skill was to be performed.	___	___	___	_____
Planning				
1. Determined expected outcomes following completion of procedure.	___	___	___	_____
2. Determined best site for BP assessment.	___	___	___	_____
3. Selected appropriate cuff size. Ensured that sphygmomanometer or electronic blood pressure machine was in patient's room.	___	___	___	_____
4. Collected and brought appropriate supplies to the patient's bedside.	___	___	___	_____
5. Ensured that patient had not exercised, ingested caffeine, or smoked for 30 minutes before assessing BP. Had patient rest at least 5 minutes before measuring lying or sitting BP and 1 minute before measuring standing BP.	___	___	___	_____
6. Drew curtain around bed and/or closed room door. Prepared bedside environment for patient safety. Ensured room was warm, quiet, and relaxing.	___	___	___	_____

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7. Explained procedure to patient. Had patient assume sitting or lying position. Allowed the patient to rest 3 to 5 minutes before obtaining a BP. Asked patient not to speak during BP measurement.	___	___	___	_____

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Implementation				
1. Performed hand hygiene and obtained BP by auscultation:	___	___	___	_____
a. Upper extremity: With patient sitting or lying, positioned forearm at heart level with palm turned up. Supported arm on table or under own arm. When sitting, supported back and instructed patient to keep feet flat on floor without legs crossed.	___	___	___	_____
b. Lower extremity: When upper extremities were inaccessible, lower extremity BP measures were obtained.	___	___	___	_____
(1) Calf BP measurements: positioned the patient supine.	___	___	___	_____
(2) Thigh BP measurements: When the patient could not be placed prone, positioned the patient supine with knee slightly bent.	___	___	___	_____
2. Exposed extremity (arm or leg) fully by removing constricting clothing.	___	___	___	_____
3. Palpated brachial artery or popliteal artery (thigh) or dorsalis pedis artery or posterior tibial artery (calf).	___	___	___	_____
4. Positioned manometer gauge vertically at eye level no more than 1 meter (1 yard) away.	___	___	___	_____
5. Auscultated BP using two-step method:	___	___	___	_____

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a. Relocated brachial or popliteal pulse. Palpated artery distal to cuff with fingertips of nondominant hand while inflating cuff rapidly to pressure 30 mm Hg above point at which pulse disappears. Slowly deflated cuff and noted point when pulse reappeared. Deflated cuff fully and waited 30 seconds.	___	___	___	___
b. Placed stethoscope earpieces in ears and ensured that sounds were clear, not muffled.	___	___	___	___
c. Relocated artery and placed bell or diaphragm chest piece of stethoscope over it. Did not allow chest piece to touch cuff or clothing.	___	___	___	___
d. Closed valve of pressure bulb clockwise until tight. Quickly inflated cuff to 30 mm Hg above patient's estimated systolic pressure.	___	___	___	___
e. Slowly released pressure bulb valve and allowed manometer needle to fall at rate of 2 to 3 mm Hg/second.	___	___	___	___
f. Noted point on manometer when first clear sound was heard.	___	___	___	___
g. Continued to deflate cuff gradually, noting point at which sound disappeared in adults. Noted pressure to nearest 2 mm Hg. Listened for 20 to 30 mm Hg after last sound and allowed remaining air to escape quickly.	___	___	___	___
6. Auscultated BP using one-step method:	___	___	___	___

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a. Placed stethoscope earpieces in ears and ensured that sounds were clear, not muffled.	___	___	___	_____
b. Relocated brachial or popliteal artery and placed bell or diaphragm chest piece of stethoscope over it. Did not allow chest piece to touch cuff or clothing.	___	___	___	_____
c. Closed valve of pressure bulb clockwise until tight. Quickly inflated cuff to 30 mm Hg above patient's usual systolic pressure.	___	___	___	_____
d. Slowly released pressure bulb valve and allowed manometer needle to fall at rate of 2 to 3 mm Hg/s. Noted point on manometer when first clear sound was heard.	___	___	___	_____
e. Continued to deflate cuff gradually, noting point at which sound disappeared in adults. Noted pressure to nearest 2 mm Hg. Listened for 10 to 20 mm Hg after last sound and allowed remaining air to escape quickly.	___	___	___	_____
7. Assessed systolic BP by palpation:	___	___	___	_____
a. Located and then continually palpated brachial, radial, or popliteal artery with fingertips of one hand. Inflated cuff to pressure 30 mm Hg above point at which pulse could no longer be palpated.	___	___	___	_____
b. Slowly released valve and deflated cuff, allowing manometer needle to fall at rate of 2 mm Hg/s. Noted point on manometer when pulse was again palpable.	___	___	___	_____
c. Deflated cuff rapidly and completely. Removed cuff from patient's extremity unless patient condition required repeated measurements.	___	___	___	_____
8. Used average of two sets of BP measurements, 2 minutes apart. Used second set of BP measurements as baseline. When readings were different by more than 5 mm Hg, performed additional readings.	___	___	___	_____

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9. Removed cuff from patient's arm or leg unless repeat measurements needed.	___	___	___	_____
10. When this was first assessment of patient, repeated procedure on other arm or leg.	___	___	___	_____
11. Helped patient return to comfortable position and covered upper arm or leg when previously clothed.	___	___	___	_____
12. Informed patient of blood pressure and recorded per agency policy. Discussed findings with patient.	___	___	___	_____
13. Placed nurse call system in an accessible location within patient's reach.	___	___	___	_____
14. Raised side rails (as appropriate) and placed bed in lowest position.	___	___	___	_____
15. Disposed of all contaminated supplies in appropriate receptacle, removed and disposed of gloves, and performed hand hygiene.	___	___	___	_____
16. Cleaned earpieces and diaphragm of stethoscope with alcohol swab as needed. Wiped cuff with agency-approved disinfectant when used between patients. Performed hand hygiene.	___	___	___	_____
Evaluation				
1. When assessing BP for first time, established baseline BP when it was within acceptable range.	___	___	___	_____
2. Compared BP reading with patient's previous baseline and usual BP for patient's age.	___	___	___	_____

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3. Used Teach-Back. Revised instruction of patient/family caregiver was not able to teach back correctly.	___	___	___	_____
Recording				
1. Record BP and site(s) assessed on vital sign flow sheet or in nurses' notes in EHR or chart.	___	___	___	_____
2. Document measurement of BP and any signs or symptoms of BP alterations after administration of specific therapies in nurses' notes in EHR or chart.	___	___	___	_____
3. Documented evaluation of patient and family caregiver learning.	___	___	___	_____
Hand-Off Reporting				
1. Reported abnormal findings appropriately.	___	___	___	_____
2. Report method of blood pressure measurement.	___	___	___	_____

Student _____ Date _____

Instructor _____ Date _____