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Monitoring the patient and recording nursing care

Nurses see the patient more than any other care provider. Therefore, nurses are in the best position to monitor the patient's progress, spot problems early and judge what care is needed to solve the problem. To do these things the nurse must use every opportunity to assess the patient, always asking the question, "What is happening to this patient?".

Whenever you enter the patient's room, carefully look at how the patient is, check all the equipment in the room, and check the environment of the room.

Here are some basic guidelines to use when you are checking what is happening to the patient.



Get background information

Before you go into a patient's room, check the chart to see what has been done today, what problems other caregivers have noted, and whether there is any other new information available about the patient. If possible, talk about this with the nurse who is going off duty.



Observe the patient

- Listen to the patient's breathing, look at his or her colour, and see whether the patient is awake.
- Immediately take the patient's vital signs if you see any signs that the patient is having trouble breathing, is breathing too fast, or his or her colour is unnaturally pale or reddish, or if the patient appears to be in distress. Report problems to the nurse in charge or the doctor.
- Do not wake up the patient for assessment or care unless the breathing or colour indicates a problem. If the patient's breathing, colour, or position in the bed suggests unconsciousness rather than normal sleep, try to wake up the patient. If you cannot rouse him or her, call for help. At the same time, make sure that the patient's airway is open; if necessary, open it by lifting the lower jaw.



Talk with the patient

- If the patient is awake, ask how he or she is and whether he or she is comfortable.
- Ask about any pain.
- Ask whether the treatment or medication given has helped.
- Ask whether the patient has been eating and drinking.
- Ask about urinary and faecal elimination.
- Note any problems the patient mentions.

If the person does not volunteer information, ask specifically about symptoms that you might expect to find, such as fatigue, nausea, or respiratory problems. If family members are present, it is helpful also to ask them how the patient seems and whether they have noted any problems. Ask them also about what the patient has eaten and drunk.



Examine the patient

Examine the patient briefly from head to toe, noting any changes or abnormalities. Pay particular attention to the problems which brought the patient into the hospital.

What you look for will depend on what the problem is and what body systems are affected by it.



Check any equipment in use

The checks you make will depend on what the patient's problem is and what equipment is being used for the problem; it may be an oxygen system, a nasogastric tube, an indwelling catheter, or an intravenous line, for example.

If the patient is receiving oxygen:

Make sure that the cannula or catheter is properly placed.

Check that the oxygen is humidified and running at the ordered number of litres per minute. Check also that there is enough oxygen in the tank.

If the patient has an intravenous line:

Make sure the intravenous line is open and the correct solution is flowing at the correct rate.

Check the site where the catheter enters the skin for any redness, warmth, or signs that the solution may be leaking from the vein out into the tissues. If the skin is swollen or pale at the site and the patient feels pain, it is likely that the fluid has gone into the tissues and the intravenous line must be taken out and put in again.

If the patient has a foley catheter in place:

Check the urine output. Look at whether the urine is clear, cloudy, reddish, or dark and concentrated.

Check the intake and output record to help you to work out the patient's fluid status.

Make sure that the foley catheter tubing is not twisted. The foley bag should not be resting on the floor.



Assess the patient's environment

It is the nurse's responsibility to see that the patient's environment is clean and safe.

- Check the overall cleanliness of the room and floor. Make sure the floor is dry.
- Check the patient's bed and the area around it. Make sure that the bedding is clean and smooth and the area around the bed is clean and tidy. Dirty eating equipment and soiled tissue can be a source of infection for the patient and the nurse.
- Check that the toilet area is clean. If possible, see that the patient has soap and a towel for washing.
- Check that the patient has what he or she needs.
- If the patient is able to drink fluids, make sure that there is fresh water by the bed.



Take the patient's vital signs

Vital signs are vital.

One of the most important aspects of assessing the patient is taking the vital signs. The patient's vital signs are temperature, pulse, breathing (respiration) and blood pressure. Changes in any of the vital signs can indicate changes in the patient's condition. Large or sudden changes should always be reported to the doctor.

- Vital signs should be checked on admission and at regular intervals after that. In many hospitals they are checked every four hours.
- When patients are in intensive care or have just come back from surgery, their vital signs are checked more frequently.
- Vital signs should also be checked:
 - ◆ before and after any invasive procedure
 - ◆ before and after giving any medication that can affect blood pressure or respiration
 - ◆ before and after any nursing procedure that might affect any vital signs, for example, walking a patient who has been on bed rest.

Always check vital signs when a patient complains of light-headedness, dizziness, being suddenly hot, or whenever the patient's condition changes for the worse.

Temperature

The body temperature is the heat of the body measured in degrees. The average temperature of an adult measured orally is between 36.7°C and 37°C.

A temperature higher than the usual average is called a fever or hyperthermia. At its first appearance, the signs of fever include:

- an increased pulse
- increased breathing
- shivering
- cold skin
- feelings of being cold (having a chill).

Clinical alert: Extremely high fevers can cause convulsions. They can damage the liver, kidneys and other organs and even cause death.

During the course of the fever, clinical signs include:

- skin that feels warm to the touch
- continued increased pulse rate and breathing
- thirst
- dehydration
- loss of appetite
- a general feeling of unease
- drowsiness, restlessness and, in severe cases, delirium.

When a fever begins to go down, the patient still feels warm and is flushed and sweating; the person may also be dehydrated but does not have chills.

A body temperature which is lower than the average is called hypothermia. The clinical signs include:

- severe shivering
- pale, cool, waxy skin
- low blood pressure (hypotension)
- decreased urinary output

- disorientation
- in severe cases, drowsiness and coma.

The nurse routinely takes the patient's temperature to check for infection. **Fever is a sign of infection.** If a patient has a fever, the nurse checks the temperature to see whether fever is continuing, getting worse, or whether the medication has reduced the temperature. The nurse also takes the temperature to see whether the care given has changed it.

The body temperature can be measured at oral, rectal and axillary (under the arm) sites. It can also be measured in the ear at the tympanic membrane (ear drum).

A mercury thermometer is generally used to measure temperature. The thermometer may have a long slender tip or a rounded tip. The slender tip is best for oral or axillary temperature; the rounded tip is used to take rectal temperature.

To read a mercury thermometer, hold it at eye level and turn it until you can see the mercury line. The upper end of the line, the highest point the mercury has reached, gives the temperature.

How to take an oral temperature

A person's temperature is usually measured in the mouth, or orally. This is the easiest way to take a temperature. If the patient is under five years old or is confused, the temperature must be taken another way in case he or she bites the thermometer and breaks it. If a patient has had cold or hot fluids or has been smoking, you must wait 15 to 30 minutes before taking an oral temperature to make sure that the temperature reading is accurate.

- Wash your hands.
- Shake the thermometer down to below 35°C.
- Put the thermometer under the patient's tongue, to the right or left of the pocket at the base of the tongue.

- Tell the patient to close his or her lips, but not the teeth, around the thermometer. Leave the thermometer in place for at least three minutes.
- Take out the thermometer and read the temperature.
- Wash the thermometer in soapy lukewarm water (never hot), rinse it in cold water, wipe it with disinfectant and store it dry.
- Wash your hands and record the temperature.

How to take an axillary temperature

To take an axillary temperature, the thermometer is put under the patient's arm (in the axilla). This is not the most accurate way to take a temperature, but it is done for adults who have inflammation of the mouth and patients who are confused. An axillary temperature is usually a half degree lower than an oral temperature.

- Wash your hands.
- Prepare the thermometer just as you would to take an oral temperature.
- Put the thermometer under the patient's arm in the axilla.
- Ask the patient to hold the arm tight against the chest and leave the thermometer in place for five minutes in children and nine minutes in adults..
- Take out the thermometer, read the temperature and clean and store the thermometer.
- Wash your hands and record the temperature.

How to take a rectal temperature

Rectal temperatures are considered the most accurate. They are usually taken only with infants and children who cannot yet hold a thermometer in their mouth without breaking it. A rectal temperature is usually a degree higher than an oral temperature. When you take a rectal temperature, use a thermometer with a rounded tip.

- Wash your hands.

- Ask the patient to lie on his or her side, with knees flexed. A child should lie on one side or prone, on your lap.
- Check the temperature recorded on the thermometer. If it reads more than 35°C, shake it down.
- Put some lubricant on a tissue and then onto the first 2.5 cm of the thermometer. The lubricant makes it easier not to irritate the membranes when you put in the thermometer.
- Ask the patient to take a deep breath and put the thermometer into the anus from 1.5 to 4 cm depending on the patient's age and size. Do not force the thermometer.
- Hold the thermometer in place for two minutes.
- Remove the thermometer, wipe it with a tissue, and discard the tissue. Read the thermometer.
- Wash and rinse the thermometer, wipe it with disinfectant, dry it and store it dry.
- Wash your hands.
- Record the temperature.

How to take the patient's pulse

The heart is a pump that pushes blood into the arteries. With each heartbeat, there is a pulsing pressure as the blood goes into the arteries. The pulse therefore reflects the heartbeat. A normal adult pulse usually is from 60 to 80 beats a minute, but the range is 60 to 100.

The pulse is faster in women than in men. It is much faster in children than in adults. The pulse increases with exercise and with stress, and when the patient has a fever. The pulse is also faster when the patient is losing blood. Some medications decrease the pulse rate and others increase it.

It is important to take the patient's pulse to find out whether it is in the normal range, and whether it is regular or not. Most of the time the pulse is taken on the thumb side of the inner wrist; this is called the radial pulse.



The radial pulse is on the thumb side of the wrist

A pulse can also be taken at several other places on the body. If you cannot get to the radial pulse because the patient has a bandage there, or you need to assess the pulse in a particular part of the body, use another site. Any pulse taken away from the heart is called a peripheral pulse.

To take the patient's peripheral pulse, whether on the wrist or at another site, you need a clock or a watch with a second hand.

- Use your index and middle fingertips or all three middle fingertips and apply moderate pressure over the pulse point, until you feel the pulsing. Never use your thumb because you have a pulse in your thumb that you could mistake for the patient's pulse.
- Count the number of beats for a full minute. After that, if the pulse is normal, count for 30 seconds and multiply by two.
- Note whether the pulse is weak, normal, or too strong (bounding).
- Note whether the pulse is regular or not.
- If the pulse is faster or slower than usual for this patient, or the pulse is irregular or bounding or weak, report this to the nurse or doctor in charge.

How to take an apical pulse

Sometimes a pulse may be so weak that you cannot hear it unless you listen to it near the heart. A pulse taken at the apex of the heart is called the apical pulse.

To take an apical pulse, you need a stethoscope and a watch which shows the seconds.



Taking an apical pulse

- Wash your hands.
- Use an antiseptic wipe to clean the earpieces and diaphragm (the flat-edged piece of the stethoscope) if they are soiled.
- Find the pulse site on the left side of the chest.
- Put the earpieces of the stethoscope in your ears, with the ear pieces pointing or facing forward.
- Put the diaphragm over the apical pulse and listen for heart sounds, which sound like "lub dub."
- Note whether the spaces between heart sounds are regular or not. This is the rhythm of the heart beat.
- Note the strength or weakness (volume) of the heartbeat.
- Count the heartbeats for 30 seconds and multiply by 2 if the rhythm is regular; count them for 60 seconds if the pulse is irregular. This is the pulse rate.
- Wash your hands.
- Record the pulse rate, rhythm and strength.

Check the patient's breathing

The normal rate of breathing, or respiration, in a resting adult is 12 (or more commonly 15) to 20 breaths a minute. The rate is higher in infants. It is also higher in a person who is exercising or under stress, and when the outside temperature is higher. Infections and respiratory disorders increase the rate as well. Some medications such as narcotics decrease respiration. When people lie flat on their back, they breathe less deeply.

It is important to check breathing when the patient is resting. It is best for the patient not to be aware that you are checking respiration, so that he or she breathes as usual. **Count the breaths while you still have your fingers on the patient's pulse, as if you were continuing to count the pulse. The patient will not notice that you are actually checking the breathing.**

- To check the **rate** of breathing, count the number of breaths for at least a minute.
- To check the **rhythm**, note whether the spaces between breaths are regular or not.
- To check the **depth** of breathing, look at the movement of the person's chest or place your hand on the person's chest to feel the movement. When the person breathes in, the ribs move upward and outward so that the lungs can expand; when the person breathes out, the ribs move in as the lungs are compressed. If there is a lot of movement of the chest, the breathing is deep; if the movement is very little, the breathing is shallow.
- Look at the amount of **effort** the patient has to make in order to breathe, and listen to the sound of the person's breathing. Normal breathing is silent and easy. Sometimes the patient is clearly working to breathe, particularly when he or she is lying flat. If the patient is working hard, you will often see tightness of the neck and shoulder muscles. Sometimes you will see that the skin has been pulled in above the sternum or below the ribs (called insuction or retraction).

- Listen for wheezing, which is a whistling or sighing sound. Wheezing is a sign of serious infection, asthma, or a blockage in the airway.
- Write down what you notice about the patient's breathing. If you see any changes in the patient, tell the nurse in charge or the doctor immediately.

Clinical alert.
Always report fast breathing. It is a sign that something is wrong. It can mean that the patient has an infection such as pneumonia, heart failure, blood loss or other problems.

How to take blood pressure

Blood pressure is a measure of the pressure that the blood makes as it moves through the body's arteries. There are two kinds of blood pressure: systolic pressure and diastolic pressure.

- Systolic pressure is the highest pressure produced when the left ventricle of the heart contracts. It is the pressure of the wave of blood going into the arteries.
- Diastolic pressure is the lowest pressure produced when the left ventricle relaxes. It is the pressure that is always within the arteries.
- Blood pressure is measured in millimetres of mercury (mm Hg) and is usually given as the systolic pressure followed by the diastolic pressure, with a slash between.

Example of blood pressure:

systolic ® **140** **diastolic**
pressure **90** − **pressure**

- The normal blood pressure of an adult ranges from 110/60 to 140/90 mm Hg, and the average is 120/80 mm Hg.

High blood pressure or hypertension is pressure that continues to be above 140/90 mm Hg.

Low blood pressure or hypotension is systolic pressure that is below 100 mm Hg.

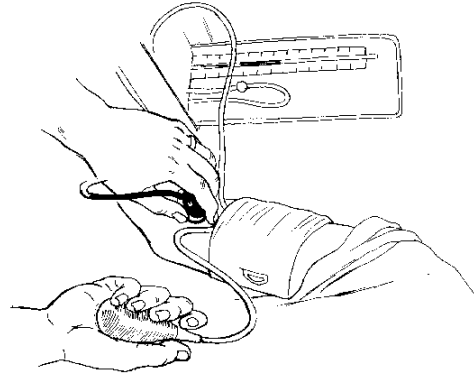
It is important to know the patient's normal blood pressure in order to see changes that may show problems.

Blood pressure is measured with a blood pressure cuff, a sphygmomanometer, and a stethoscope.

The stethoscope is used to listen to the sounds of the blood in the artery.

Take the blood pressure in the patient's arm using the brachial artery, which is the artery in the middle of the elbow crease.

- To begin, wash your hands.
- Put the patient in a comfortable position, sitting or lying on one side, with the arm to be measured slightly bent and supported.



***Place stethoscope over the brachial pulse
in the elbow crease***

- The cuff should be at the level of the heart.
- Wrap the cuff around the upper arm and fasten it. The bladder inside the cuff has to be directly over the artery. The lower border of the cuff should be about 2.5 cm above the elbow crease (called the antecubital space).
- Feel the artery with your fingertips. It should be in the centre of the antecubital space. This is called the brachial pulse.
- While you are feeling the brachial pulse with one hand, close the valve and pump up the cuff with the other hand. Pump until the reading on the sphygmomanometer is 30 mm above the point where the brachial pulse disappears.
- Put the diaphragm of the stethoscope over the brachial artery.
- Release the valve on the cuff slowly so that the pressure goes down at the rate of 2-3 mm per second.
- Listen for the sounds.

The systolic pressure is the pressure at which you first hear tapping sounds. Make sure that you hear two sounds, to be sure you have not mistaken some other sound for the blood sound.

- Note the reading on the sphygmomanometer when you first hear the tapping sounds. That is the systolic pressure reading.
- Again, note the reading on the sphygmomanometer when you hear the last sound; that is the diastolic pressure reading.

The diastolic pressure is the point at which the very last sound is heard.

- Release the valve and deflate the cuff quickly.
- Remove the cuff from the patient's arm and record the blood pressure readings, with the systolic first and the diastolic second.
- If there are any significant changes in blood pressure from the last time it was measured, report this immediately.



Plan the nursing care

After checking how the patient is (the status), plan the care you will give this day.

The plan of care will include:

- procedures ordered by the doctor
- nursing measures to provide comfort and promote recovery.



Record the patient's status and nursing care

Recording or noting information is an essential part of nursing care. After you have checked the patient and provided care, you need to note three types of information:

- important information about the status of the patient
- the care you gave the patient
- the patient's response to your care.

The main reason for writing down information about the patient is so that the caregiver who follows you knows what has been happening. The next caregiver needs to know how the patient was before, to see if anything has changed. For example, you take vital signs not only to decide whether the patient has a problem needing your immediate attention, but also to provide baseline data for the nurse who follows you. Then when that nurse takes vital signs, he or she can quickly see whether they are stable or whether there are changes that need to be watched or which need to be dealt with immediately.

Write a nurse's note only about what you think is important. A nurse's note might look like this:

Date	Time	
15/9/97	0800	Dressing changed and drainage checked. Wound is clean. Patient says she is in less pain than yesterday but continues to be nauseated. S. Ramos, RN

It is very important to write your notes as soon as you leave the patient. If you wait until later, you will forget what you have seen or done or you will confuse what you saw in this patient with what you saw in others. Never wait to record.



Evaluate the care given

After caring for the patient, always go back to see if your nursing care has been effective. For example, if you give the patient medication for pain, go back to see if the patient is feeling more comfortable.

If your nursing measures have not been effective, you may need to plan and carry out other measures to help the patient.

Reminder

The patient's status should be assessed every time the nurse gives care.

Your observations and the information you gather from the patient help you to decide whether the patient is getting better or is experiencing problems that need attention.