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EACYHU - CAMERON SANCHEZ

Most nurses (59.8%) also reported relying on oxygen saturation to evaluate respiratory dysfunction, and 27.4% indicated that they make quick estimates of the respiratory rate. Current practices for vital signs monitoring were considered to be time consuming (21.0%) and overwhelming (35.3%).

Give a shortened SBAR with the situation, any changes in vital signs, mental status, respiratory, GI, GU, lab work), and your recommendation. For the charge nurse. You give a handoff report twice: once at the beginning of the shift and one closer to the end. In the beginning, say the situation, any drips, and the plan for the patient. And if you anticipate that you'll need help from her, this is the time to speak up.

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Nurses play an essential role in influencing patient safety every day. However, taking observations or measuring vital signs is increasingly seen as a task based activity rather than the gathering of clinical information. This poses a real danger for patients.

Count the number of pulses for 60 seconds. Count the number of pulses for 30 seconds, and multiply by 2 - if the HR is regular. Count the number of pulses for 15 seconds, and multiply by 4 - if the HR is regular. As described, it is important that a nurse assesses the pulse for regularity.

Vital sign changes are late signs of brain deterioration. Respiratory pattern provides a clear indication of brain functioning. Note for Cheyne Stokes, rapid, irregular, clustered, gasping or ataxic breathing. Temperature alterations may indicate dysfunction of the hypothalamus or the brain stem.

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VITAL SIGNS IN ADULTS

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No significant association was found in relation to the proportion of hours registered nurses worked as long shifts. Conclusion: On days when a higher proportion of hours worked by healthcare assistants are from long shifts, the risk of delaying vital signs observations is higher, suggesting lower job performance. While longer shifts are thought to require fewer staff resources to maintain nurse-to-patient ratios, any benefits may be lost if staff become less productive.

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Vital sign monitoring is a fundamental component of nursing care. We're taught in nursing school that a patient's pulse, respirations, blood pressure, and body temperature are essential in identifying clinical deterioration and that these parameters must be measured consistently and recorded accurately.

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A comprehensive peer-review screening process was performed. Studies were included that described the surrounding issues of handover, vital signs, ED, transition of care and ward. Results: Five studies were included in the final review, one specific to nursing and four specific to emergency medicine. Vital signs were perceived to be an important inclusion in clinical handover, and the communication of vital signs in handover was perceived to be indicators for patient safety and risk factors ...

[Nursing handover of vital signs at the transition of care ...](#)

3.2.1 Vital sign monitoring should be undertaken at the commencement of a nursing shift as part of a nursing assessment for each patient. 3.2.2 Vital sign frequency should then be established for the rest of the shift based on the initial assessment. 3.2.3 The longest acceptable gap between vital signs is 10 hours(excluding patients

Patient Observation (Vital Signs) Policy - Adult

This then helps to emphasise the importance of vital signs in contemporary nursing practice as 'better monitoring of patients implies better care' for this reason it is the nurses responsibility to ensure accuracy of the data, interpret the vital signs findings and to report any abnormalities (Lynn, 2008 ; Kyriacos et al, 2011 p.3225).

[The Importance of Vital Signs in Contemporary Nursing ...](#)

The vital signs include the assessment of the pulse, body temperature, respirations, blood pressure and oxygen saturation, which is the newest of all the vital signs. Vital signs are considered vital to the rapid assessment of the client when it is necessary to determine major changes in the client's basic physiological functioning.

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