SUBJECT: VITAL SIGNS

1. PURPOSE:

The purpose of this policy is to discuss the meaning of “routine” vital signs, explain the importance of monitoring body temperature, list the types of thermometers and routes for measuring temperature, describe the physiology of the pulse, explain the technique for assessment of the pulse, describe the assessment of respirations, define the term blood pressure, state the rationale for blood pressure measurement, describe the newest addition to a set of vital signs—pain assessment—as the fifth vital sign, identify nursing responsibilities related to the assessment of vital signs, and describe the role of new technologies in the assessment of vital signs.

2. POLICY:

The taking of Vital Signs consists of obtaining the “temperature”, “pulse”, “respirations”, “blood pressure”, and the newest fifth vital sign “pain assessment”. Verbal and written description will be presented and communicated in this sequential order (TPR, BP, and Pain Assessment). Oxygen Saturation (SPO2) shall be taken as clinically indicated.

1. Nursing personnel are expected to know the normal range of each vital sign. During the shift, whenever there is a question about the well being of any individual, the taking of vital signs is to be accomplished as often as deemed necessary. A physician’s order is not required. The assessing of vital signs becomes a required part of the overall picture when assessing an individual’s condition. It is used to establish trends and make comparison of changes in condition. Do not wait for the next routine time if an untoward trend is developing or suspected.

2. Nursing staff shall obtain and document a full set of vital signs for the following situations including but not limited to:
   a. Upon admission to the hospital, then daily for 7 days
   b. During the annual physical examination
   c. Upon re-admission, transfer to unit from court visit or other hospital, or any intrahospital transfer to another unit
   d. Monthly on all individuals/clients
   e. Individuals in restraint and/or seclusion as near the beginning of the shift as possible and every eight hours while in restraint and/or seclusion
f. Individuals who complain of feeling ill before calling to the attention of HSS and physician/MOD

g. In preparation for those individuals to be evaluated for Sick Call by the Medical physician or MOD

h. Every shift while on antibiotics for 3 days unless otherwise ordered by unit physician

i. Before and after surgery or invasive diagnostic procedures

j. While on medications that alter cardiovascular, respiratory, or temperature control status (e.g. antihypertensives, digitalis, antipyretics, cardiotonics, bronchodilators, etc.)

k. Within one hour after administration of a PRN medication given specifically for its effect on vital signs (e.g. antipyretics, antihypertensives, cardiotonics, bronchodilators, etc.)

l. Medically fragile or individuals receiving oxygen shall have vitals taken every shift unless otherwise ordered by the physician

m. Twice a day for a minimum of three (3) weeks starting three days prior to the first dose of Clozapine (recorded on the Clorzapine Medication Record)

n. Whenever the individual’s perception of health status changes (e.g. individual verbalizes, “I feel funny”, or “I'm feeling faint”)  

o. Throughout a medical emergency

p. Immediately after a fall (if a Fall Risk Assessment is completed), take a complete set of vital signs including orthostatic Blood Pressure readings

3. Nursing personnel are expected to exercise clinical judgment and take vital signs as warranted by the individual’s condition. Vital Signs shall also be taken when requested by the Shift Lead, RN/Case Manager, NOD, or Physician

4. Vital signs on admission shall be recorded on the “Initial Screening Assessment” (Identification/Admission Note, “Nursing Assessment”), and “Vital Signs Record” vital signs shall be recorded on:
   a. Vital Signs Record
   b. Monthly Vital Signs Record

5. All abnormal vital signs or deviation from the individual’s normal baseline are to be reported to the Medical Physician/MOD, Shift Lead, RN/Case Manager, and NOD. Abnormal Vital Signs are to be documented in the IDN (Wellness and Recovery Notes MH #5624) including physician notification and action taken. This information shall be reported at the Change of Shift Meeting to the oncoming shift to assist with maintaining continuity of care.

6. Vital signs influenced by medication shall be recorded on the MAR (Medication and Treatment Record MH 5764) [e.g. Apical pulse shall be individuals prior to receiving cardiac or antihypertensive drugs; the blood pressure shall be taken at least weekly while giving beta blockers such as Propranolol (Inderal)]. (Refer to the P&T Manual for further parameters.

7. The Apical Pulse rate will be taken for one full minute prior to the administration of digitalis preparations or other cardiac drugs. Record on
the MAR (MH #5764). If the pulse is 60 or below, or irregular, withhold the medication and promptly notify the physician immediately.

8. The individual is to be assessed for pain every time the individual’s pulse, blood pressure, temperature, and respirations are checked.

9. Nursing personnel are to provide client teaching/instruction regarding the taking of Vital Signs to assist with gaining individual’s cooperation with the procedure and to promote individual involvement and partnership with their treatment. Document all client teaching in the IDN notes.

3. **ASSESSMENT:**

The accurate Assessment of vital signs is an important and crucial part of nursing care. Nursing personnel are expected to know how to take vital signs, interpret the data, communicate this data to others, and plan nursing interventions appropriately. The taking of vital signs as a part of the nursing process (assessment, nursing diagnosis, planning nursing intervention, evaluation) utilizing a deliberate problem-solving approach. Assessment is a systematic way of collecting data. It determines nursing diagnosis for development of the individual care plan. Taking vital signs means gathering data for the database.

1. The usual adult temperature range is 96.4 to 99.4 F, with the average being 98.6 F. temperature regulation is diminished in the elderly. Because the elderly are generally less active their temperatures are usually subnormal, the circulation is slower, and there is less power to compensate for fluctuations in external temperature. Fever is an elevation of body temperature beyond the normal range. Causes may be viral or bacterial infection, drug reaction, brain lesion, or reaction to other body pathology.

2. Blood pressure is influenced by problems with cardiac output and peripheral resistance. Hypertension occurs when the arterial pressure is significantly above average for the person involved. Obesity, heredity, or nervousness may cause primary hypertension. Secondary hypertension is unknown etiology but may accompany some other pathologic systemic condition.

3. Certain factors influence the regulation of breathing. Chemical factors depend on the presence and amount of carbon dioxide that stimulates the chemoreceptors on the medulla and stimulates breathing. Physical factors include lung inflation, which stimulates nerve receptors and allows passive expiration to occur. This causes blood pressure changes to occur which in turn, causes breathing to become slower and shallower.

4. The Pulse rate is also governed by the medulla. The rate increased during conditions such as hemorrhage and shock. The elasticity of the vessels also affects the rate. During atherosclerosis, the plaque lining the vessels hardens
and constricts the diameter. This constriction diminishes the amount of blood able to be pumped through the vessels.

5. All individuals will be assessed for pain. When pain is an identified problem, individualized pain management goal will be established and regular assessments will take place until the problem is resolved. Pain assessment includes: location and intensity; but in most cases should include other dimensions such as psychological and spiritual distress.

4. **OUTCOME CRITERIA:**

Nursing staff will recognize the interrelationships between vital signs, physiological activity, and pathophysiological changes and will utilize the nursing process problem-solving approach to analyze the findings and take appropriate action.

5. **THE TAKING OF VITAL SIGNS - GENERAL INFORMATION:**

Temperature, pulse, respiration, blood pressure, and pain assessment (considered the fifth vital sign) together comprise a set of Vital Signs. These are considered “vital” because they are indispensable indicators of an individual’s current state of health. Even when the individual seems to be in a state of high-level wellness, it is often important to assess the vital signs as a means to establish baseline data with which to judge the significance of any future deviations from what appear to be the “characteristic” or “normal”.

Obtaining the “oxygen saturation” level (a.k.a. “Pulse Ox” or SpO2 level) is an important indicator of respiratory functioning.

**Temperature:**

The Tempa-dot (disposable chemical dot thermometer) may be used for routine temperature taking, monthly vital signs, and screening purposes. However, if a temperature is greater than 99.5 or less than 96, or when there are signs and symptoms of infection, the Welch Allyn/LifeSign Vital Signs Digital oral thermometer shall be used to confirm and/or monitor the individual.

**Types Of Thermometers Used At CSH:**

<table>
<thead>
<tr>
<th>TYPE</th>
<th>Temp-a-Dot</th>
<th>Welch Allyn/ LifeSign Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREENING Temperatures</td>
<td>Yes</td>
<td>Yes</td>
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-4- N.P.P No. 322
### Tempa-Dot (Disposable Chemical Dot Thermometer)

#### NURSING ACTION

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<table>
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<tbody>
<tr>
<td><strong>A.</strong> Wash hands before and after procedure.</td>
<td><strong>A.</strong> Prevents spreading contamination.</td>
</tr>
<tr>
<td><strong>B.</strong> Explain the procedure to the individual.</td>
<td><strong>B.</strong> Ensure the individual has not had hot/cold drink(s), smoked within 30 minutes, or has undergone unusual exertion.</td>
</tr>
<tr>
<td><strong>C.</strong> Remove thermometer from protective wrapping. Be sure the thermometer has been stored in a cool, dry place such as a refrigerator and that it remains sealed until use.</td>
<td><strong>C.</strong> Opening protective case activates the dye dots. If thermometer dots are blue upon opening, it has been exposed to 96°F or higher. Place in freezer to restore effectiveness.</td>
</tr>
<tr>
<td><strong>D.</strong> Place thermometer in the individual's mouth under the tongue. Have the individual keep his/her mouth closed.</td>
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#### KEY POINTS

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**E.** Position thermometer under the individual's tongue on either side of the mouth as far back as possible.

**F.** Have individual close mouth on the thermometer.

**G.** Leave in place for one full minute.

**H.** Remove thermometer and wait then seconds before reading the temperature.

**I.** Read the temperature as the last dye doe that has changed color.

**J.** Discard thermometer in the biohazardous waste container.

**Axillary Temperature:**

**NURSING ACTION**

**A.** Explain procedure to individual.

**B.** Pat axilla dry if moist/damp.

**C.** Place the thermometer in a sheath and place in the axilla and ask individual to fold arm across his/her chest.

**D.** Leave in place for 7 to 10 minutes.

**E.** Remove thermometer, discard sheath in biohazardous waste container.

**KEY POINTS**

**A.** Client teaching assists with gaining individual’s cooperation.

**B.** Moisture in the axilla may cause an incorrect reading.

**C.** This “wind – like” position provides a large axillary pocket and prevents displacement of the thermometer.

**D.** The normal range is 96.6°F to 98.4°F.

**Rectal Temperature:**

**NURSING ACTION**

**A.** Explain procedure to individual and provide privacy.

**KEY POINTS**

**A.** A rectal temperature is taken for individuals fro whom the oral method is
inappropriate (e.g. comatose), when clinically indicated, when Neuroleptic Malignant Syndrome (NMS) is suspected, or when ordered by the physician.

B. Wash hands before and after procedure.  
B. Prevents spreading contamination.

C. Apply sheath and lubricant the distal ½ inch.  
C. A lubricant will reduce the friction. Gloves should be worn and the thermometer should be held in place to prevent accidental breakage or other trauma to the individual’s rectum.

D. Position individual on side with top leg flexed and separate buttocks. Insert thermometer about 1 to 1½ inches.  
D. Allows visualization of the anus and placement of the thermometer at the correct angle.

E. Hold in place until sensor records the reading.  
E. Holding the thermometer prevents displacement and insures accurate reading. The normal range for a rectal temperature is 98.6° – 100.4° F.

F. Remove thermometer and discard sheath in the biohazardous waste container.

Welch Allyn/Life Sign Vital Signs Monitor Digital Oral Thermometer Key Points:

The Welch Allyn/Life Sign Vital Signs monitor is capable of taking an automatic Blood Pressure, oral temperature, and pulse oximetry. It is located on all units, Admissions Suite, and in the Employee Clinic (refer to the Welch Allyn/LifeSign Vital Signs Monitor Operation’s Manual).

Taking a 4 – Second Oral Temperature:

The oral probe has a blue tip.

- Remove the probe from the holder and load the probe cover.
- Hold the probe under the individual’s tongue for approximately 4 seconds.
- When the temperature measurement is complete, a tone will sound and the temperature will be displayed.
- Replace the probe in the holder before attempting to take another temperature measurement.

6. PULSE:

General Information:

1. Use the fingertips when taking the client’s pulse, preferable the third and fourth (the middle and ring) fingers. The thumb and index fingers have pulses of their own which can be mistaken for that of the client.
2. Common pulse sites are the temporal, carotid, brachial, radial, femoral, and pedal.

3. The pulse should be taken in addition with vital signs whenever the temperature or blood pressure is taken, as well as prior to administration of digitalis preparations, Inderal, etc.

4. When taking pulses determine the rate, rhythm, and amplitude.

Definitions:

1. Rapid, accelerated: Above normal range for age and activity. Associated with fever or inflammation, increased physical activity, etc.

2. Tachycardia: Very rapid pulse over 120 beats per minute; may be too fast to count. May occur sporadically as in paroxysmal tachycardia (more than 140 beats per minutes), toxic thyroid condition, or advanced infection, increased physical activity.

3. Bradycardia: Below 60 beats per minute. May occur in aged person with digitalis overdose or beta-blockers e.g. Inderal.

4. Irregular, intermittent: Variations in force and frequency; may have occasional skipped beats. If a skipped beat is at a regular interval, not the
pattern of beats. Found in heart disease, anxiety, increased caffeine, nicotine intake.

5. Dicrotic pulse: A double beat or second weak wave between usual heart strokes. The weak beat is not counted as a regular beat. Indicative of low arterial tension.

6. Bounding, full: Higher or harder pulse then usual; disappears quickly. Result of shortened ventricular systole and reduced peripheral pressure, inflammation, or fever.

7. Thready: Weak, scarcely palpable beat; little appreciable relaxation between beats. Observed with faintness, shock, and heavy hemorrhage.

8. Unequal: Pulse rate not the same between wrists, wrist and ankle, or wrist and apical. May indicate weak heart contractions, obstructed, or poor circulation.

Procedure:

**NURSING ACTION**

A. Explain procedure to individual.

B. With individual in a comfortable position, gently press the third and fourth (middle and ring) fingers over the artery.

C. After locating pulse, count the beat for 30 seconds and multiply by two (2) for the rate.

D. Record the pulse rate, rhythm, and amplitude.

**KEY POINTS**

A. Client teaching assists with gaining individual’s cooperation.

B. Never use your thumb or index finger to take a pulse because the pulsation in the thumb and index artery can interfere with an accurate reading.

C. If pulse is irregular or if individual has a history of heart problems, take pulse for a full minute. Assess the rhythm and amplitude.

D. Describe pulse amplitude by using the following:
   - 3+ = Bounding, increased
   - 2+ = Normal
   - 1+ = Weak, thready
   - 0 = Absent

Apical Pulse:

**NURSING ACTION**

A. Position the individual in a supine position and provide privacy.

B. Warm the stethoscope in hand and place over the apex of the heart. (Normally located at the fifth intercostal space at the mid-clavicular line).

C. Move the stethoscope until the **KEY POINTS**

A. The supine position promotes comfort and ease of location the heart sounds.

B. Cold stethoscope can cause the rate to increase. The Apical Pulse is best heard in this area because the heart is close to the chest wall.

C. There is a first (lub) and a
loudest beats are heard and count for a full minute.
D. Record (document) findings and report as appropriate (MD, NOD, etc.).

second (dub) sound for each heartbeat.
D. Indicate Apical Pulse with the letters AP after reading.

Respirations:

Definitions:

1. Abnormal or diaphragmatic: Chiefly the diaphragm is used for breathing, causing rise and fall in abdomen; chest walls appear nearly at rest. May be formal, but extreme splinting of chest wall may indicate pleurisy, pericarditis, or fractured ribs.
2. Apnea: Temporary absence of breathing. May occur in profound sleep or in coma, heart and kidney disease, or brain injury.
3. Cheyne-stokes: Gradual increase in rate and depth followed by gradual subsiding and a period of apnea. Result of disturbance of respiratory center and usually a forerunner of death.
4. Costal or thoracic: Muscles of chest and ribs expand the chest cavity markedly. Occurs when peritoneum or diaphragm is inflamed.
5. Labored or dyspneic: Difficult and usually audible breathing with dilated nostrils, anxiety, gasping, and air hunger. Usually accompanied by pain and insufficient oxygen from problems in lungs, circulation, or hemoglobin.
6. Rapid: Above normal rate for age and activity. Usually ratio to pulse is 1:4. Occurs in fever, infection, or as in labored respirations, described above.
7. Slow: Below normal rate for age and activity. Usually associated with increased intracranial pressure, coma, or depressant drugs.
8. Stertorous: Rattling, bubbling, or moist breathing sounds. May be snoring, mouth breathing, or may be caused by fluid in lungs.
9. Stridulous or strident: High pitched crowing or barking sound during inspiration. Indicates obstruction in glottis or respiratory passage as in diphtheria.

Respirations:

NURSING ACTION

A. Explain procedure to the individual.
B. Count the number of times the individual takes a breath for 30 seconds. If abnormal, count respirations for a full minute. Note respiratory rate by watching the rise

KEY POINTS

A. Note indications of acute or chronic respiratory problems.
B. A complete cycle of inspiration and expiration constitutes one respiration. The best time to assess the respiratory rate is immediately after taking the pulse since an
and fall of the individual’s chest. Multiply 30 second count by 2.

C. Record rate and rhythm, and report as appropriate

individual who is aware that the respiratory rate is being taken can alter it.

C. For complete assessment, not the character of the respirations as well as the rate.

7. **BLOOD PRESSURE:**

General Information:

Blood pressure varies with age, sex, altitude, muscular development, emotional state, and time of day. Blood pressure may also vary from one arm to the other.

The cuff bladder should be 20% wider than the diameter of the extremity being used.

For accurate readings the individual should be in a relaxed position for 5 to 10 minutes and the arm should be supported at heart level. Do not apply cuff over clothing.

The interval between systolic and diastolic pressures should be noted regularly. This measurement is called the pulse pressure. Because diastolic pressure remains relatively constant, the pulse pressure usually is considered to be a good indicator of stroke volume. In hypovolemic shock, the pulse pressure often is decreased. Report a steady decrease in pulse pressure to the physician.

Procedure:

**NURSING ACTION**

A. Clean earpieces of stethoscope with alcohol.

C. Explain procedure to the individual.

D. Apply the sphygmomanometer cuff to the individual’s arm above the antecubital fossa.

E. Locate the brachial pulse with fingertips.

F. Place the diaphragm of the stethoscope firmly overt the artery so that sound can be transmitted without distortion.

**KEY POINTS**

B. To prevent cross contamination.

D. Do not use the arm on the same side an A – V shunt or mastectomy.

F. The edges of the diaphragm should all be flat against the skin to limit the amount of extraneous noise, but not so hard that the
G. Inflate the cuff to a point about 20 to 30 mm Hg above the last systolic reading or until pulsation can neither be felt nor heard. Do not leave the cuff inflated any longer than necessary.

H. Determine the systolic pressure by slowly releasing the pressure valve. Note the position of the arrow on the gauge.

I. Determine the diastolic pressure by noting the point at which the first muffled sound is heard (Diastolic IV) and the point at which the sounds and fluctuation of the gauge cease (Diastolic V).

J. The blood pressure also may be measured by the palpation method. Apply the cuff to the upper arm and locate the radial pulse. Inflate the cuff. The radial pulse will be obliterated at this point. As the cuff is slowly deflated, note the point at which the radial pulse is again palpable. The reading at which the first beat is felt is the systolic reading. If is generally 10 mm Hg below the systolic measurement by auscultation.

Pain Assessment:

Pain assessment is now required as a fifth vital sign and is to be assessed at the same time as other vital signs are taken. Pain is to be assessed and treated promptly, effectively, and for as long as the pain persists. Pain assessment is performed in a manner that is appropriate to the individual. The pain assessment shall be noted in the individual’s chart in a manner consistent with other vital signs.
Under the new standards, an individual has the right to appropriate pain assessment and management.

Use of a pain scale lets the individual describe pain in a way that is meaningful to the individual. Some individuals respond best to word scales; others find that pictures or number scales help them describe their pain intensity accurately.

**Pain Intensity Rating Scales:**

The scale helps the individual quantify their current levels of pain.

<table>
<thead>
<tr>
<th>No Pain</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Pain as bad as it can be</th>
</tr>
</thead>
</table>

It is now required that all health care staff record pain assessment each time vital signs are recorded for each individual. Using the zero to ten pain assessment scale, a recording of pain e.g. 2/10, is acceptable. The Registered Nurse is required to take appropriate action based on deviations from normal.

If pain is rated more than 4/10 or is unacceptable to the individual, notify physician.

Progress notes should clearly delineate the plan and rationale for the pain treatment.

**Descriptive Pain Intensity Scale:**

<table>
<thead>
<tr>
<th>No Pain</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
</table>

If your client is currently in pain, determine and document the location, duration, character (including its intensity and radiation, if any), and frequency. Explore these points with the individual:

- Does the pain have a pattern? If so, does it vary?
- When was the pain most intense in the past 24 hours?
- Does anything relieve the pain or make it worse?
- Does the individual take pain medication to manage the pain? If so, is it effective? Does it cause any unpleasant adverse reactions?
- Does the pain interfere with you daily activities, for example: sleeping, or eating?
Also conduct a physical assessment and examine the painful site. Document your findings.

Assessing non-verbal individuals:

Although nothing is more reliable than the individual’s self-report of pain, you must rely on other information if your client cannot use a pain-rating scale. If, for example, the individual has a painful condition, or has undergone a painful procedure, you may have enough information to justify administering analgesics.

Other pain indicators include:
- Distressed facial expressions and behavior – frowning, grimacing, crying, and expressions of fear or sadness.
- Look for muscle contraction around the mouth and eyes.
- Unusual movements (such as restlessness or slow, guarded, or rigid movements) or the absence of movement
- Attention-seeking behavior, such as repetitive banging or outbursts
- Vocalizations, such as groaning, moaning, crying, or noisy breathing

First, try to determine a baseline of behavior that seems to indicate pain. Evaluate changes in behavior after the administration of an analgesic.

After giving pain medication, evaluate the individual’s response in 30 to 60 minutes (depending on the drug and administration route).

Make sure your assessments are culturally appropriate, keeping in mind that cultural mores and personal values can affect the individual’s beliefs about pain and response to pain. Even if the individual directly, so always ask, and believe what he or she says. The individual’s self-report is the most accurate indicator of the existence and intensity of pain. Don’t second-guess your client or assume that he or she is exaggerating because he or she is laughing or sleeping.

Teaching Points:
Help your client understand why effective pain management is important and how uncontrolled pain can hamper recovery.

Be open and flexible when assessing and planning for client (And Family If Appropriate) teaching and teach on the individual’s level. Consider his or her values and beliefs, culture, literacy, education level, language, emotional barriers to pain relief, physical and cognitive functions and limitations.
Pulse Oximeter:

General Information:

The Oximeter used at this facility is the SIMS BCI 3301 Oximeter. It provides fast, reliable SpO² and pulse rate measurements. It will operate accurately over an ambient temperature range of 32 to 131°F (0 to 55°C). It is portable and lightweight, weighing only 9 ounces (225 grams) without the batteries. It uses three standard alkaline batteries (type LR 14) or three rechargeable (type KR27/50) NiCad “C” cell batteries. Battery life is approximately twenty-four (24) hours in continuous mode or eighty (80) hours in spot check mode. It automatically turns off after the individual’s finger is removed from the sensor. A “low battery” indicator lights when about two hours of battery use remains.

Procedure:

<table>
<thead>
<tr>
<th>Nursing Action</th>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Make sure the equipment is in good working order and that the sensor is attached to the oximeter before using.</td>
<td>A. Hold the connector rather than the cable when connecting or disconnecting the finger sensor to the oximeter. <strong>DO NOT</strong> use excessive force, unnecessary twisting or kinking when connecting, disconnecting, storing, or when using the sensor.</td>
</tr>
<tr>
<td>B. When placing the sensor on the individual, allow the cable to lie across the palm of the hand and parallel to the arm of the individual. Place the sensor on the distal end of the finger.</td>
<td>B. The index finger is commonly used. Be sure to fully insert the individual’s finger into the sensor.</td>
</tr>
<tr>
<td>C. To begin measurement, press the “I” key. When turned on, the oximeter goes through the following power-up sequence:</td>
<td>C. If normal functioning does not occur, see Operator’s Troubleshooting Chart (in NP&amp;P #610 – Pulse Oximetry) for help.</td>
</tr>
<tr>
<td>• The pulse strength barograph segments light one at a time.</td>
<td></td>
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<tr>
<td>• The oximeter’s software revision is momentarily displayed</td>
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</tr>
<tr>
<td>• The client number for spot check printouts it momentarily displayed. The format for the client number display is “P” followed by the number. For example, P 14 means the client number is 14.</td>
<td></td>
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<tr>
<td>After a few seconds the % SpO² value,</td>
<td></td>
</tr>
<tr>
<td>1. Press on</td>
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</tr>
</tbody>
</table>
| pulse rate, and pulse strength barograph should be shown. | 2. % SpO² value displayed  
3. Pulse rate displayed  
4. Pulse strength barographs sweeping with pulse  
5. Low battery indicator |

D. The SpO² display shows the individual's blood oxygen saturation, calculated as a percentage. The pulse rate display shows the individual’s pulse rate in beats per minute (BPM). The pulse strength barographs show the individual’s pulse strength; the barograph is scaled logarithmically to indicate a wide range of pulse strengths.

E. Press the “O” key to turn off the oximeter. The oximeter turns off automatically two minutes after the sensor is removed from the individual’s finger or after the sensor is disconnected from the oximeter.

E. This feature extends the battery use time.