HERZING UNIVERSITY | SCHOOL of NURSING

VITAL SIGNS & PAIN ASSESSMENT
SKILL VALIDATION

Student Name: _____ Date: _____

	Points Allowed	1st Attempt	2nd Attempt
Preparation			
Perform I-CHECK: Introduce yourself, **Check armband (two patient identifiers),** Hand hygiene, Explain procedure, Check order, Keep privacy	+1		
Determine the appropriate arm for blood pressure measurement (i.e., consider presence of IV-line, mastectomy, fistula, or injury)	+1		
Manual Blood Pressure			
Apply appropriately sized sphygmomanometer with a snug fit, correct alignment, and cuff placed 2-5 cm above the brachial artery	+1		
Position patient with arm supported at heart level and feet flat on the floor	+1		
Ask patient what their BP typically is (this step prevents overinflation of cuff & avoids auscultatory gaps)	+1		
Obtain the patient's blood pressure: • Put on the stethoscope with earpieces angled forward, place the diaphragm over the brachial artery & inflate cuff 30mmHg above estimated systolic pressure to avoid missing an auscultatory gap • Deflate cuff 2mmHg per second while listening for Korotkoff sounds, noting when first Korotkoff sound appears (systolic BP) & the last audible Korotkoff sound (diastolic BP) • Continue to slowly deflate the cuff for a bit longer to make sure the Korotkoff sounds don't reappear, and then rapidly deflate the cuff	+3		
Correctly state blood pressure measurement (within 4 mmHg)	+1		
Heart Rate			
Place fingertips on radial artery and press lightly until pulse is felt	+1		
Count beats for 30 seconds if regular (then double it) or 60 seconds if irregular	+1		
Correctly state the heart rate (within 2 bpm), noting rate, rhythm, and force (3+ = full, bounding, 2+ = normal, 1+ = weak, thread, 0 = absent)	+1		
Respiratory Rate			
Watch the rise and fall of the chest or abdomen **without letting the patient know** you are counting (e.g., pretend to still be checking the pulse)	+1		
Count breaths for 30 seconds if regular (then double it) or 60 seconds if irregular	+1		
Obtain oxygen saturation	+1		
Correctly state the respiratory rate (within 1 breath per minute)	+1		
Temperature (Oral)			
Ask patient if they have recently eaten, consumed hot or cold liquids, or smoked. If yes, wait 15 minutes prior to assessing an oral temperature	+1		
Attach a disposable cover to the thermometer and position the thermometer at the base of the tongue in either of the posterior sublingual pockets, and ask the patient to close their lips around it	+1		
Wait for the thermometer to beep, indicating the reading is complete and dispose of the cover, and read the temperature accurately	+1		

Pain			
Ask if the patient is experiencing any pain (the "patient" should report a common ailment like a headache) and assess using the OPQRST method: • Chief Complaint: Are you having any pain? Where is it located? • Onset: When did the pain begin? • Provocation: What makes the pain worse? • Quality: How do you describe the pain? • Radiation: Does the pain spread elsewhere? • Severity Scale: Explain and use the 0-10 scale to assess intensity • Timing: Is the pain constant or intermittent? How long does it last?	+7		
Post-Procedure			
Document patient's vital signs (blood pressure, heart rate, respiratory rate, temperature) and pain assessment. *No points, but required*			
Total Points (successful/unsuccessful): 21 out of 26 needed to be successful			
Comments **1st Attempt:** **2nd Attempt:**			

Evaluator Initials or Signature: _____ Date: _____

1ST Attempt Pass _____**/ Needs Remediation**_____

Evaluator Initials or Signature: _____ Date: _____

2nd Attempt Pass _____**/ Lab Fail**_____