

# How to perform respiratory assessment

Smith J, Rushton M (2015) How to perform respiratory assessment. *Nursing Standard*. 30, 7, 34-36.  
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## Rationale and key points

This article aims to assist practitioners to perform a respiratory assessment.

- ▶ A logical and structured approach to respiratory assessment, such as the 'look, listen and feel' approach, should be undertaken.
- ▶ The respiratory rate is an early indicator of deterioration of a patient's condition.
- ▶ Signs of clinical deterioration should be responded to in a timely manner.
- ▶ A track and trigger scoring tool can be used to evaluate physiological data, develop a management plan and indicate future investigations.

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## Authors

Joyce Smith Lecturer in adult nursing.

Melanie Rushton Lecturer in adult nursing.

Both at University of Salford, Salford, England.

Correspondence to: [J.Smith2@salford.ac.uk](mailto:J.Smith2@salford.ac.uk)

## Keywords

assessment, clinical procedures, clinical skills, respiratory care

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## Preparation and equipment

- ▶ The environment should be safe to minimise risk to the practitioner and the patient. The patient's bed area should be assessed for any furniture or wires that may cause a risk.
- ▶ The patient's privacy and dignity should be maintained by drawing the curtains around the bed.
- ▶ The patient should be rested and in a comfortable position for the assessment. If not, the practitioner should ask for help to position the patient before starting the assessment. This may not be appropriate if the patient is acutely unwell.
- ▶ The practitioner should ensure that all equipment required is available and in good working order, including:
  - A watch (or clock) with a second hand.
  - A stethoscope.
  - A pulse oximeter.
  - An early warning score chart.
- ▶ Hand hygiene should be performed (Hillier 2015).

## Procedure

1. Assess the patient's respirations after checking the pulse, so that the patient does not alter their breathing.
2. Count the respiratory rate for one minute. The normal resting respiratory rate is between 12 and 20 regular and rhythmic breaths per minute.
3. Undertake the 'look, listen and feel' approach to assessment, as advocated by the Resuscitation Council (UK) (2011).

## Look

4. Observe the rhythm, symmetry and depth of the patient's respirations. Extra respiratory effort is indicated by the patient pursing their lips or flaring their nostrils. Evidence of the patient using their accessory muscles, for example abdominal or scalene muscles, indicates increased work or difficulty breathing. Any sign of tracheal deviation may indicate a tension pneumothorax.
5. Observe the patient's colour – pale or flushed – and whether they are showing any signs of cyanosis. Peripheral cyanosis is a bluish colour of the skin and nail beds that indicates

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