Communication Listening & Speaking

Vital Signs & Symptoms Assessment

Aj. Natthaya Cherngchalard Chooprom
Faculty of Nursing, NPRU

Learning Objectives

- Identify key English vocabulary for vital signs and common symptoms.
- Practice listening to and understanding spoken vital sign numbers and symptom descriptions.
- Learn and practice asking assessment questions in English (Vital Signs & PQRST).
- Practice speaking to report vital signs and symptoms clearly.
- Build confidence in nurse-patient communication in English.

Clear Communication = Safer Care

Accuracy

Mishearing a number or misunderstanding a symptom can lead to significant errors in patient care, directly impacting outcomes.

Patient Trust

Good communication builds strong rapport and trust between nurses and patients. Patients feel truly heard and respected, which enhances their cooperation and satisfaction.

Efficiency

Effective communication prevents misunderstandings and reduces the need for clarification, saving valuable time and streamlining workflows in a busy clinical setting.

Teamwork

Clear and concise reporting, often using structured tools like SBAR, ensures that the entire healthcare team understands the patient's current status, fostering a coordinated approach to care.

The Vital Five (or Six!)

Temperature

The body's heat balance, often measured orally, rectally, or tympanically.

Pulse / Heart Rate (HR)

The number of times the heart beats per minute, indicating cardiovascular function.

Respiration / Respiratory Rate (RR)

The number of breaths a person takes per minute, reflecting lung function.

Blood Pressure (BP)

The force of blood against artery walls, measured as systolic over diastolic pressure.

Oxygen Saturation (SpO2)

The percentage of oxygen-carrying hemoglobin in the blood, indicating oxygenation levels.

Pain (The "Fifth" Vital Sign)

Subjective discomfort, often assessed using a numerical rating scale to guide pain management.

Talking About Vital Signs

Vital Sign	Key English Terms
Temperature	Celsius (°C), Fahrenheit (°F), Oral, Rectal, Axillary, Tympanic. Fever/Pyrexia, Hypothermia.
Pulse	Beats per minute (bpm), Strong, Weak, Thready, Regular, Irregular. Tachycardia, Bradycardia.
Respirations	Breaths per minute, Shallow, Deep, Labored. Tachypnea, Bradypnea, Dyspnea.
Blood Pressure	Millimeters of mercury (mmHg), Systolic / Diastolic. Hypertension, Hypotension.
SpO2	Percentage (%), Hypoxia.

Listening Practice: Catching the Vitals

Tips for Active Listening

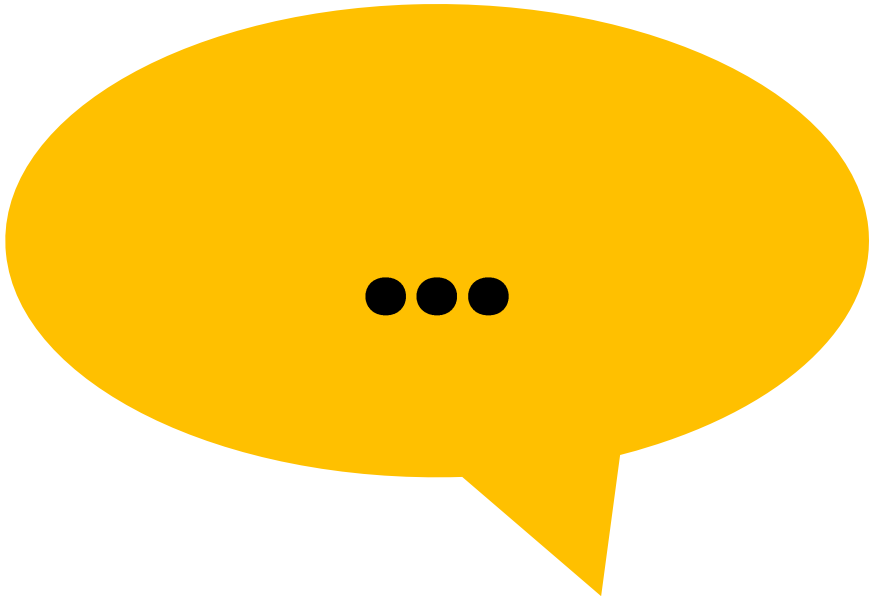
- Numbers can sound similar (e.g., 15 vs 50, 13 vs 30). Pay close attention to subtle differences.
- Always listen for the ***context*** and consider ***normal ranges*** to help verify what you hear.
- Practice hearing numbers in sequence (e.g., "BP is one-twenty over eighty") to improve comprehension.
- Listen for descriptive words (e.g., "Pulse is 90 and *regular*") as they provide crucial additional information.

Normal Ranges (Adult)

- Temperature: 36.5–37.5°C (97.7–99.5°F)
- Pulse: 60–100 bpm
- Respirations: 12–20 breaths/min
- Blood Pressure: < 120/80 mmHg
- SpO2: 95–100%

Activity 1: Listen & Record

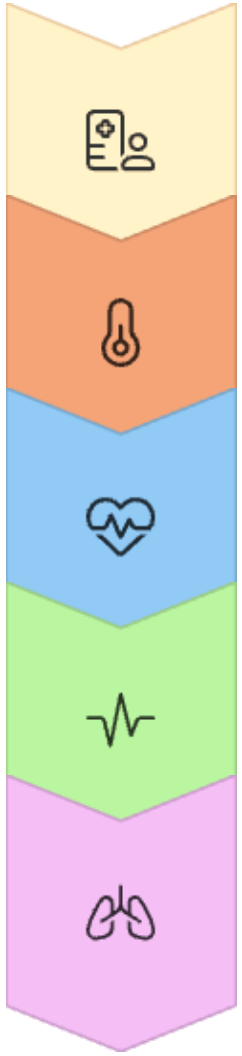
Task: Write down the vital signs you heard.



Your Recording Table

Temperature:	
Pulse:	
Respirations:	
Blood Pressure:	
SpO2:	

How to Ask: Taking Vitals



Introduction

"Hello, I'm [Your Name], your nurse. I need to check your vital signs now, is that okay?"

Temperature

"I'm going to take your temperature. Can you please open your mouth / put this under your arm?"

Pulse/SpO2

"Can I check your pulse and oxygen level? Please give me your finger."

Blood Pressure

"I need to check your blood pressure. Can I use this arm? Please relax your arm."

Respirations

(Usually assessed quietly while checking pulse, no direct question needed).

How to Report: SBAR

1 Situation (S)

Clearly state who you are, your location, the patient's identity, and the concise reason for your communication.

2 Background (B)

Provide relevant patient history, including diagnoses, recent procedures, and current treatments that are pertinent to the situation.

3 Assessment (A)

Report your key findings, including vital signs and any observed symptoms. This is where you clearly state, "His latest vitals are: T 38.5, P 96, R 22, BP 140/88, SpO2 94%."

4 Recommendation (R)

Propose a clear course of action or what you believe needs to happen next for the patient's care.

Activity 2: Practice Time!

Role-Play Scenario

Work in pairs for this activity.

- **Nurse 1:** Practice *taking* vitals using the polite phrases from Slide 8. (Patient 1 responds simply, e.g., "Yes, that's fine.").
- **Nurse 1:** Practice *reporting* these vitals to Nurse 2 (acting as a charge nurse or doctor) using clear, precise numbers.
- After the first round, switch roles so both participants get to practice both parts.

Scenario Vitals for Practice

Vital Sign	Reading
Temperature	37.2°C
Pulse	78 bpm
Respirations	16 breaths/min
Blood Pressure	110/70 mmHg
SpO2	98%

Understanding Symptoms: PQRST

P: Provokes / Palliates

What makes the symptom better or worse?
For example, "Does anything make the pain better?" or "What were you doing when it started?"

Q: Quality / Quantity

What does it feel like? How would you describe it? (e.g., "Is the pain sharp, dull, or aching?") How much of it is there? (e.g., "How much sputum are you producing?").

R: Region / Radiation

Where is the symptom located? Does it spread to other areas?
(e.g., "Can you point to where it hurts?" or "Does the pain travel anywhere else?").

S: Severity / Scale

How bad is the symptom? Rate it on a scale, typically 0–10. (e.g., "On a scale of 0 to 10, with 10 being the worst pain imaginable, what would you rate your pain?").

T: Timing / Onset

When did the symptom start? How long has it been occurring? How often does it happen?
(e.g., "When did this dizziness begin?" or "How long does the shortness of breath last?").

Describing How Patients Feel

- **Pain**: Aching, Sharp, Dull, Burning, Stabbing, Throbbing.
- **Nausea / Vomiting**: Feeling sick, Throwing up, Queasy.
- **Dizziness / Lightheadedness**: Feeling faint, Room spinning (Vertigo).
- **Shortness of Breath (SOB) / Dyspnea**: Difficulty breathing, Can't catch my breath.
- **Fatigue / Tiredness**: Feeling weak, No energy.
- **Fever / Chills**: Feeling hot, Shivering.

Credit: https://media.istockphoto.com/id/1182393306/vector/flu-disease-prevention-cold-symptoms-flat-line-icons-set-fever-headache-sneeze-sore-throat.jpg?s=612x612&w=0&k=20&c=2XSseUNbW058g7CE90OQsfi9G55TVA7fL_S5yXjvyGw=

Listening to Symptom Descriptions

Effective listening is crucial. Pay close attention to adjectives, intensity words, and timing cues when patients describe symptoms. These details help you understand the full picture.

- **Listen for PQRST clues.**
- **Adjectives: "sharp pain", "constant dizziness".**
- **Intensity: "severe", "mild", pain scales.**
- **Timing: "started yesterday", "comes and goes".**

Activity 3: What Does Mr. Lee Say?

Listen carefully to Mr. Lee's description of his chest pain. Identify the PQRST elements from his words.

Mr. Lee's Symptom

"Oh, nurse... this pain in my chest... it started about an hour ago. It's a really heavy, crushing feeling, right here [points to center chest]. It even goes up my left arm a bit. Nothing makes it better. It's really bad... maybe a 9 out of 10. It’s constant."

PQRST Breakdown

- Provokes: Nothing helps.
- Quality: Heavy, crushing.
- Radiates: Center chest, to left arm.
- Severity: 9/10.
- Timing: Started 1 hr ago, constant.

How to Ask: PQRST Questions

Asking the right questions is vital for accurate assessment. Use these phrases to gather detailed symptom information.

Provokes

"What makes the symptom better or worse?" "Did you do anything for it?"

Quality

"Can you describe the symptom? What does it feel like?"

Region/Radiation

"Can you show me where the symptom is?" "Does it move anywhere else?"

Severity

"On a scale of 0 to 10, how would you rate it?"

Timing

"When did it start? How long does it last?" "Is it constant or does it come and go?"

Activity 4: Ask PQRST!

Practice your PQRST questioning skills in a role-play scenario. Focus on clear questions and active listening.

Nurse Role

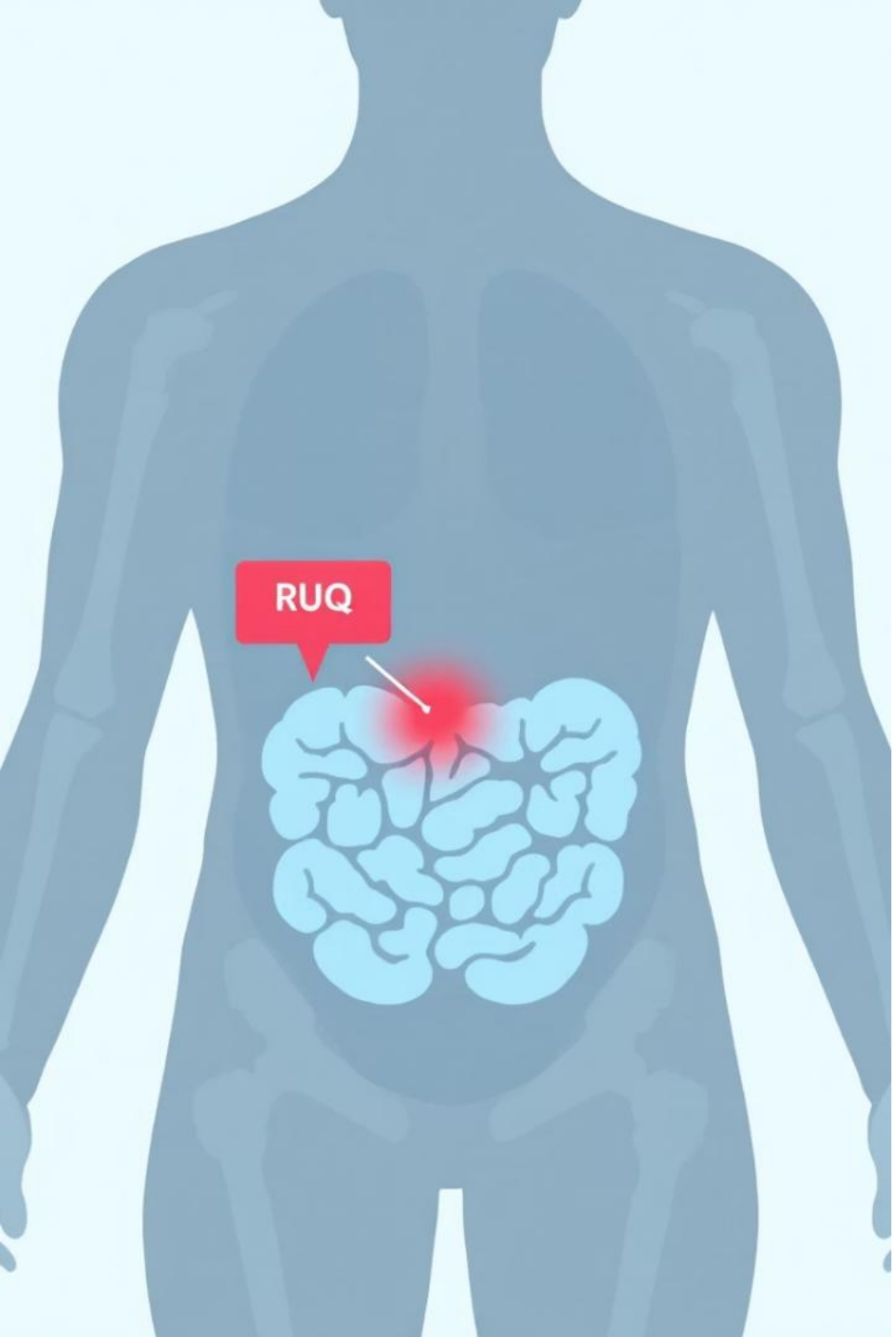
Use PQRST questions from the previous slide to assess the patient's symptom.

Patient Role

Choose one symptom like headache or dizziness and have PQRST details in mind.

Switch Roles

Ensure both partners practice asking and understanding.



Case Study: Ms. Anna J.

Review Ms. Anna J.'s case. Integrate her symptom description with her vital signs for a complete assessment.

Patient Story

Ms. Anna J., 45, "severe abdominal pain." Started last night after dinner. Sharp, stabbing pain in RUQ. Comes in waves, 10/10. Nauseous, no vomiting. Moving makes it worse.

Vital Signs

T=38.2°C, P=105, R=20, BP=135/85, SpO2=97% RA.

Activity 5: What Would You Say?

In groups, analyze Ms. Anna's data. Prepare to report your findings to a doctor using English and identify a priority nursing action.

1

Listen & Analyze

Review all of Ms. Anna's data, including VS and PQRST findings.

2

Speak & Plan

Formulate how you would report these findings to a doctor in English (focus on S & A in SBAR).

3

Nursing Action

Determine one priority nursing action for Ms. Anna J.

Key Communication Phrases

Keep these essential English phrases handy for various nursing communication scenarios. Practice them regularly.

Introducing

"Hello, I'm [Name], your nurse. I need to check..."

Listening Cues

"Uh-huh", "I see", "Go on", "Can you tell me more about...?"

Asking (VS)

"Can I check your...? Please relax..."

Asking (Symptoms)

"Can you describe...? Where is...? On a scale of 0-10...? When did it start?"

Reporting

"Patient is..., Vitals are..., Patient reports..."

Practice Makes Perfect!

- ✓ Remember: Confidence comes with practice.
- ✓ Listen to English medical dramas/podcasts.
- ✓ Practice with colleagues!

Thank You!