

高等学校创新教材
供本科护理学专业用

护理专业英语

主编 谷岩梅

 人民卫生出版社

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前 言

《护理专业英语》是护理本科创新教材体系中的一门专业课教科书。本教材的编写严格按照全国医学高等教育护理学专业培养方案对专业英语教学的要求进行选材、设计,注意突出直观性、专业性、实用性和系统性。本教材的主要内容是高年级学生学完基础英语和护理专业知识后所修的护理的英语词汇、常用会话、中西方护理差异以及 CGFNS 样题解析,旨在提高学生英语水平层次和专业知识,了解西方国家护理文化及护理专业用语。本教材注重培养学生独立获取知识、创新能力及合作意识,注重提高学生思想道德素质和文化素质。

本教材共十二个单元,每单元设置一个护理知识主题和护理技能项目以及一个临床护理交流场景。内容涉及生命体征、清洁卫生护理、给药以及内科、外科、产科、儿科和精神科等专科护理知识及护理接诊、交接班、急救、健康教育等临床医护、护患、护护沟通实际场景,每单元都包含五大板块:阅读课文、护理技能、医务剧视听、综合应用及 CGFNS and NCLEX_RN 样题,各板块之间既相对独立又互相联系,内容深入浅出,循序渐进。医务剧视听资源可参考互联网视频网站如 www.tudo.com、www.youku.com 及 www.56.com 等,搜索主题为“急诊室的故事”、“实习医生格蕾”、“Grey’s Anatomy”和“豪斯医生”等。本教材总设计学时为 60 学时,每单元为 5 学时。

本教材的编写团队是一个优秀而特殊的团队,在这个团队中,一半是来自护理教学一线的优秀教师,另一半是来自外语教学一线的语言教学专家。由于本教材的特殊性,每一个章节都需要护理专业和外语专业老师的合作才能完成,这无疑加大了编写难度。但一路走来,那些原本陌生的声音逐渐熟悉;那些照片中的笑脸逐渐映入记忆;原本只有目录的两页逐渐变为一摞厚厚的稿纸;这其中的辛苦和劳累,和谐与合作,都犹如酝酿新生命般的神圣与幸福。在打印出最后一页稿纸时,心中最想说的只有两句:感谢您,各位参加编写的老师;愿我们的学生能从我们的汗水中受益。

谷岩梅

2008 年 10 月

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Unit 1

PART ONE

Words to know

Interventions:

(Nursing Interventions) actions performed by a nurse, including independent interventions—activities nurses are licensed to initiate on the basis of their knowledge and skills, dependent interventions—activities carried out under the physician's orders or supervision, or according to specified routines

Health behaviors:

actions people take to understand their health state, maintain an optimal state of health, prevent illness and injury, and reach their maximum physical and mental potential

Health status:

state of health of an individual at a given time

Hypothermia:

core body temperature below the lower limit of normal

Intake and Output:

measuring and recording of all fluid taken in and excreted during a 24-hour period, recorded as I/O

Level of consciousness:

state of alertness, ranging from alert and oriented to coma

Oral report:

taped report delivered in a report room or while nurses are making client rounds

Stat Order:

medication to be given immediately and only once

Validation:

form of feedback that provides confirmation that both parties have the same basic understanding of the message and the feedback

Septicemia:

condition that exists when bacteria enters the bloodstream and spreads through all of the body's systems

Shift Report:

report to other nurses at the change of shifts to delegate responsibility and describe what has been done

TEXT

Physical Evaluation

A physical evaluation, also known physical examination, is a process in which a physician examines various organ systems and other parts of the body. As the standard tool used to monitor health and diagnose the source of many diseases, it represents the cornerstone of preventive medicine. It is far better to prevent a disease or condition than to treat it, and better to treat it early before it progresses. A physical evaluation is usually the first step in helping to find and treat the source of what ails the patient.

Physical examinations have several purposes, including disease screening, assessing risks for future health problems, assessing management of chronic diseases or conditions, suggesting tips for healthier lifestyle, updating vaccinations, building a physician-patient relationship. Patients visit a physician either in response to symptoms that may have arisen, or as a means of preventative care. A physical examination typically includes four phases:

1. Inspection.
2. The physician makes a visual overview of the patient, or of a specific body part.
3. The physician touches and/or manipulates parts of the patient's body. The purpose is to examine aspects of size, consistency, location and tenderness.
4. The physician listens to sounds in the body, usually with the aid of a stethoscope. Frequently, this involves listening to a patient's lungs, heart and intestines. The frequency, intensity, duration, number and quality of sounds are noted.
5. The physician taps body parts with fingers, hands or small instruments. The purpose is to examine aspects of size, consistency, borders and presence or absence of fluid in

body organs.

6. A physician will examine a patient by assessing: vital signs, general appearance, eyes, ears, nose, throat and mouth, neck, particularly the thyroid gland and cervical lymph nodes, respiratory, cardiovascular and gastrointestinal systems, breast examination for women, genitals (including men's prostate and women's pelvic area). Muscles, joints, bones and skin. Neurological and psychiatric condition.

A routine physical examination normally begins with a review of the patient's medical history by the physician. The physical examination offers an opportunity to speak to a physician about health concerns. Some patients find it helpful to bring a list of relevant questions for their physician to the appointment. If it is a routine check-up with no pressing concerns or current symptoms, no preparation is necessary prior to the exam. However, the physician may request that certain information be gathered prior to the appointment. For example, information about a family history of disease in close relatives (including parents, siblings, grandparents, aunts and uncles) may help a physician to be watchful for symptoms related to the disease if it has a genetic component.

A patient with symptoms that may be of concern should describe them in detail to the physician. The description should include what the symptoms are, where they are located, when they began, what they feel like, whether they get worse or better over time, and any other patterns. Also, if a patient complains of certain symptoms when making the appointment, the physician may request that certain items be prepared prior to the exam.

Physical examinations can range from simply measuring blood pressure and listening to a patient's heart to a more thorough exam, which usually includes the following: height and weight measurements. Vital statistics, including temperature, heart rate and blood pressure. Examining the skin for any rashes, dryness, irritation, open sores, bleeding or abnormal color and checking moles for possible signs of skin cancer. Checking the spine for proper alignment. Listening to a patient's lungs for evidence of fluid. Examining the patient's ears and hearing. Checking for signs of swelling around the eyes, or in the hands or feet. Checking the chest, breasts and abdomen for tender areas, lumps or enlarged organs, as well as signs of swelling. Checking the eyes for clarity, movement and the pupils' response to light, as well as the back of the eye and any signs of vision changes. Looking at the teeth, gums and throat and asking about the patient's oral health habits. Checking the thyroid gland at the base of the neck while the patient swallows, as well as listening to the blood vessels in the neck. Examining joints and muscles for tenderness, swelling or motor difficulties. Feeling the lymph nodes under the arm, around the neck and in the cervical area for any swelling or pain. Examining men's prostate gland and testicles and women's pelvic area. Checking reflexes of some musculoskeletal systems.

The physician may also perform the following: cholesterol test. A blood test that measures a person's total cholesterol, low-density lipoprotein cholesterol, high-density lipoprotein cholesterol and triglycerides. High cholesterol levels can lead to a buildup of fatty deposits in the arteries, a condition called atherosclerosis. This raises the risk of heart attack and stroke. Colon and rectal cancer screening. There are several different types of tests that can help screen for colon or rectal cancer. These include fecal occult blood tests, flexible sigmoidoscopy (examination of the lower portion of the colon with a thin, flexible tube called a sigmoidoscope), colon X-ray (examination in which the patient receives an injection of liquid barium, which looks bright white on X-rays and can help highlight irregularities), and colonoscopy (similar to the flexible sigmoidoscopy, except the entire colon is examined). Bone-density measurement. Scan of the lower back, hip area, wrist or heel that measures the density of bones. Many different types of scans can be used, including ultrasound, computed axial tomography (CAT) scan and dual energy X-ray absorptiometry (DEXA). Once the physical examination is completed, the physician may decide that additional evaluation of the patient is warranted. The recommendation may be based on the patient's medical history and any findings during the physical examination, even if symptoms are not present. Depending on the suspected condition, a number of tests may be ordered by the physician to aid or rule out the diagnosis of a condition.

In the past, experts suggested that adult patients also receive regular physical examinations, even when they were feeling healthy. It was long argued that because some conditions did not present symptoms, especially in the early stages, a yearly exam was essential to good basic health. However, in recent years this approach has been re-evaluated. Today, many experts are urging a less rigorous examination schedule. The U. S. Public Health Services Preventive Services Task Force now recommends that healthy adult patients forgo annual physical examinations in favor of individual testing every one to three years depending on medical history, sex, age, other risk factors and the state of health. Recommended examinations for women include: mammograms. Every one to two years after age 40. Pap smears. At least every three years after beginning sexual activity or after turning 21. Cholesterol checks. Beginning at age 45, or age 20 for those who have other risk factors for coronary heart disease. Blood pressure. Beginning at age 18. Blood test for diabetes. Every three years beginning at age 45, or age 18 for those at high risk, such as patients who are overweight, have a family history of diabetes or other risk factors. Colorectal cancer tests. Beginning at age 50 with a frequency that depends on the type of test in discussion with the patient's physician. Osteoporosis tests. Beginning at age 65, or age 60 for women at increased risk for osteoporotic fractures. The recommendations for men include the following: cholesterol checks. Beginning at age 35, or age 20 for those who have other risk factors for coronary artery disease. Blood pressure. Beginning at age 18. Blood test for diabetes. Every three years beginning at age 45, or age 18 for those at high risk, such as patients who are overweight, have a family history of diabetes or other risk factors. Colorectal cancer tests. Beginning at

age 50 with a frequency that depends on the type of test in discussion with the patient's physician. Prostate cancer screening. Consult with a physician. It should be noted that specific screening recommendations vary between health organizations. Individuals should consult with a physician to determine the screening schedule that is most appropriate for them.

Preparing questions in advance can help patients to have more meaningful discussions with healthcare professionals. Patients may wish to ask their doctor the following questions about physical examinations: How often should I schedule a physical examination? Will the frequency change as I get older? Will you have to draw blood during my physical examination? Will I have to provide a urine sample during my physical examination? Will I experience any pain or discomfort during my physical examination? What else will my physical examination involve? How long will my physical examination last? Are there any preparatory steps I can take before my examination to help you diagnose my condition more accurately? Are there any forms I need to complete before the examination? Do I need to stop using any medications before my physical examination? What exactly will you look for during my physical examination? What do the results of my examination indicate? Based on the results, do you think I would benefit from seeing a specialist? Will I have to schedule any follow-up appointments after this examination? With my personal and family medical history, are there any special tests that should be included in my physical examination?

NEW WORDS, PHRASES & EXPRESSIONS

1. **manipulate** /mə'nɪpjuleɪt/ *vt.* manually examine and treat a part of the body (用手)检查、治疗身体的某部位
2. **intestine** /ɪn'testɪn/ *n.* the lower part of the alimentary canal from the end of the stomach to the anus 肠, 小肠
3. **thyroid** /'θaɪrɔɪd/ *n.* a large ductless gland in the neck of vertebrates secreting hormones which regulate growth and development through the rate of metabolism 甲状腺, 甲状软骨
4. **cervical** /'sɜ:vɪkəl/ *adj.* of or relating to the neck or the cervix 颈的, 子宫颈的
5. **lymph** /lɪmf/ *n.* a colorless fluid containing white blood cells, drained from the tissues and conveyed through the body in the lymphatic system 淋巴, 淋巴液
6. **gastrointestinal** /'gæstrəʊɪn'testɪnəl/ *adj.* of or relating to the stomach and the intestines 胃肠的
7. **neurological** /nju:əəʊ'lɒdʒɪkəl/ *adj.* of or relating to the nerve systems 神经学上的
8. **psychiatric** /saɪkɪ'ætrɪk/ *adj.* of or relating to the study and treatment of mental disease 精神病学的, 精神病治疗的
9. **alignment** /ə'lɑɪnmənt/ *n.* putting in a straight line or bring into line 队

10. **prostate** /'prɒsteɪt/ *n.*
a gland surrounding the neck of the bladder in male mammals and releasing a fluid forming part of the semen 前列腺
11. **pelvic** /'pelvɪk/ *adj.*
of or relating to the pelvis or the organs it encloses 骨盆的
12. **musculoskeletal** /,mʌskjʊləʊ'skelɪtəl/ *adj.*
of or relating to the musculature and skeleton together 肌(与)骨骼的
13. **cholesterol** /kə'lestərəʊl/ *n.*
a sterol found in most body tissues, including the blood, where high concentrations can promote arteriosclerosis 胆固醇
14. **lipoprotein** /lɪpə'prəʊti:n/ *n.*
any of a group of soluble proteins that combine with and transport fat or other liquids in the blood plasma 脂蛋白
15. **triglyceride** /traɪ'glɪsɪərəɪd/ *n.*
any ester formed from glycerol and three acid radicals, including the main constituents of fats and oils 甘油三酯
16. **atherosclerosis** /,æθə,rəʊsklɪə'rəʊsɪs/ *n.*
a form of arteriosclerosis characterized by the degeneration of the arteries because of the build-up of fatty deposits 动脉粥样硬化
17. **barium** /'beəriəm/ *n.*
a mixture of barium sulphate and water, opaque to X-rays, which is given to patients requiring radiological examination of the stomach or intestines(检查肠胃用的)硫酸钡水溶液
18. **colonoscopy** /,kəʊlə'nɒskəpi/ *n.*
an examination of the colon by means of a flexible tube inserted through the anus 结肠镜检查
19. **ultrasound** /'ʌltrə,sound/ *n.*
ultrasonic waves 超声波
20. **warrant** /'wɒrənt/ *vt.*
justify; guarantee 保证, 辩解, 担保, 批准
21. **forgo** /fɔ:'gəʊ/ *vt.*
abstain from; go without; relinquish 作罢, 放弃
22. **mammogram** /'mæmə,græm/ *n.*
an image obtained by mammography 乳房 X 线照片
23. **osteoporosis** /,ɒstɪəʊpə:'rəʊsɪs/ *n.*
a condition of brittle and fragile bones caused by loss of bony tissue, esp. as a result of hormonal changes, or deficiency of calcium or vitamin D 骨质疏松
24. **pap** /pæp/ *n.*
the nipple of a breast 乳头
25. **smear** /smɪə/ *n.*
a material smeared on a microscopic slide etc. for examination 显微镜涂片

Notes

- It is far better to prevent a disease or condition than to treat it, and better to treat it early before it progresses:
Prevention is better than cure.
Comparative degree of adjective can be modified by the following adverbs: even, a lot, a bit, a little, still, much, far, yet, by far, etc.
e. g. A. Things are far worse than expected.
B. The patient recovered even faster than expected.
- means; method; way; approach
- with the aid of; with the help of
- consistency; the state of always being the same in thought, behavior, etc.
- In addition; besides
- Some patients find it helpful to bring a list of relevant questions for their physician to the appointment.
Here, "it" is a formal object. The real object is the infinitive; to bring a list of relevant questions for their physician to the appointment.
e. g. We think it our duties to give hands to the earthquake-stricken victims.
- clarity; clearness
- lead to; result in
- sigmoidoscopy 乙状结肠镜检查
- absorptiometry (放射) 吸收测定法; 吸收测量术
- The U. S. Public Health Services Preventive Services Task Force 美国公共卫生服务和预防服务专门工作组
- in favor of; on the side of 支持; 赞成
- colorectal 结肠直肠的
- consult with; take counsel 商量; 商议
- in advance; ahead of time

UNDERSTANDING THE TEXT

- In addition to a physical examination, the physician may ask a patient to _____.
A. bring questions to the exam B. prepare a family history
C. review the medical history D. diagnose a genetic disease
- A cholesterol test does not measure _____.
A. low-density lipoprotein B. triglycerides
C. fatty deposits D. high-density lipoprotein
- The U. S. Public Health Services Preventative Services Task Force recommends _____.
A. annual physical examinations B. individual testing every year
C. mammograms for women after age 40 D. pap smears every 1~2 years
- Diabetes is not _____.

- A. diagnosed using a bone scan B. diagnosed using a blood test
C. tested for every 3 years D. a hereditary disease
5. Patients may wish to ask their physicians _____.
- A. why I need a physical examination
B. how often I should schedule a physical examination
C. what time I should schedule my physical examination
D. when my last physical examination was
6. It is recommended that only men get a _____.
- A. cholesterol check B. colorectal cancer checks
C. blood pressure checks D. prostate examination

NURSING SKILLS

Vital Signs

Vital signs reflect changes in functions of the body. Monitoring a client's vital signs should be a thoughtful, scientific assessment. Vital signs must be evaluated with reference to the client's present and prior health status and be compared with accepted normal standards. Some medical facilities have policies about how often to take the client's vital signs. Physicians may also order a vital sign to be taken at specific times. Ordered assessments, however, should be considered the minimum. A nurse should measure vital signs more often if the client's health status requires it. Vital signs are routinely assessed in the following order: temperature first; pulse and respirations are taken while the thermometer is in place, if possible. Respirations should be assessed while your fingers are still touching the pulse point, so that the client will be unaware and not alter the breathing pattern. The blood pressure should follow the other vital signs.

Body temperature reflects the balance between the heat produced and the heat lost from the body. When the amount of heat produced by the body exactly equals the amount of heat lost, the person is in heat balance. A number of factors affect the body's heat production, mainly including basal metabolic rate (BMR), muscle activity, thyroxine output, epinephrine, sympathetic stimulation and fever. Nurses should be aware of the other factors that can affect a client's body temperature, including age, diurnal variations, exercise, hormones, stress and environment.

The four most common sites for measuring body temperature are oral, rectal, axillaries, and the tympanic membrane. Each of the sites has advantages and disadvantages. The tympanic membrane, is becoming the preferred site for taking body temperature. Like the sublingual oral site, the tympanic membrane has an abundant arterial blood supply. The tympanic infrared method is quickly becoming the method of choice in clients over 3 months of age.

The oral site is an equally preferred site. This method reflects changing body temperature more quickly than the rectal method. Rectal temperature readings are considered to be the most accurate. The axilla is the preferred site for measuring temperature in newborns because it is accessible and offers no possibility of rectal perforation. Nursing students should check facility protocol when taking the temperature of newborns, infants, toddlers, and children. Clients for whom the axillary method of temperature assessment is appropriate include adult clients with oral inflammation or wired jaws, clients recovering from oral surgery, clients who are breathing through their mouths, irrational clients, and clients for whom other temperature sites are contraindicated. In addition to the four common sites for measuring temperature, the forehead may also be used. Forehead temperature measurements are most useful for infants and children where a more invasive measurement is not necessary. If the forehead indicates a temperature elevation, a glass or electronic thermometer should be used to obtain a more accurate measurement.

The pulse is a wave of blood created by contraction of the left ventricle of the heart. When an adult is resting, the heart pumps about 5 liters of blood each minute. This volume is called the cardiac output. In a healthy person, the pulse reflects the heartbeat. In other words, the pulse rate is the same as the rate of the ventricular contractions of the heart. However, in some types of cardiovascular disease, the heartbeat and pulse rates can differ. The rate of the pulse is expressed in beats per minute (BPM). A pulse rate varies according to a number of factors. Assessing a client's pulse, the nurse should consider each of the following factors: age, sex, exercise, fever, medications, hemorrhage, stress, and position changes.

Nine of the sites where a pulse is commonly taken are the following:

1. Temporal, where the temporal artery passes over the temporal bone of the head. The site is superior and the lateral to the eye.
2. Carotid, where the carotid artery runs between the trachea and the sternocleidomastoid muscle. Never press both carotids at the same time as this can cause a reflex drop in blood pressure or pulse rate.
3. Apical, at the apex of the heart. In an adult this is located on the left side of the chest, no more than 8 cm to the left of the sternum and at the fourth, fifth, or sixth intercostal space. For a child 7 to 9 years of age, the apical pulse is located at the fourth or fifth intercostal spaces. Before 4 years of age, it is left of the midclavicular line (MCL); between 4 and 6 years, it is at the MCL.
4. Brachial, at the inner aspect of the biceps muscle of the arm (especially in infants) or medically in the antecubital space (elbow crease).
5. Radial, where the radial artery runs along the radial bone, on the thumb side of the inner aspect of the wrist.
6. Femoral, where the femoral artery passes alongside the inguinal ligament.
7. Popliteal, where the popliteal artery passes behind the knee. This point is difficult to

- find, but it can be palpated if the client flexes the knee slightly.
8. Posterior tibial, on the medial surface of the ankle where the posterior tibial artery passes behind the medial malleolus.
 9. Pedal, where the dorsalis pedis artery passes over the bones of the foot. This artery can be palpated by feeling the dorsum of the foot on an imaginary line drawn from the middle of the ankle to the space between the big and second toes. The radial site is most commonly used. It is easily found in most people and is readily accessible.

When assessing the pulse, the nurse collects the following data: the rate, rhythm, volume, arterial wall elasticity, and presence or absence of bilateral equality. The nurse should also teach the client or family member to monitor the pulse prior to taking medications that affect the heart rate, telling the client to report any notable changes in heart rate or rhythm to the health care provider and ensuring that the client or family member is aware of what pulse findings should be reported and to whom.

Respiration is the act of breathing. External respiration refers to the interchange of oxygen and carbon dioxide between the alveoli of the lungs and the pulmonary blood. Internal respiration is the interchange of these same gases between the circulating blood and the cells of the body tissues. Inhalation or inspiration refers to the intake of air into the lungs. Exhalation or expiration refers to breathing out or the movement of gases from the lungs to the atmosphere. Ventilation is also used to refer to the movement of air in or out of the lungs. Hyperventilation refers to very deep, rapid respirations; hypoventilation refers to very shallow respirations. There are basically two types of breathing. Costal breathing involves external intercostal and accessory muscles. It can be observed by the movement of the chest upward and outward. Diaphragmatic breathing involves contraction and relaxation of the diaphragm. The abdomen moves with the diaphragm's contraction and downward movement.

Resting respiration should be assessed when the client is relaxed. Both exercise and anxiety affect respiratory rate and depth. Respirations may also need to be assessed after exercise to identify the client's tolerance to activity. Before assessing a client's respirations, a nurse should be aware of the client's normal breathing pattern, the influence of health problems on respirations, any medications or therapies that might affect the client's respirations and the relationship of respiration to cardiovascular function. The rate, depth, rhythm and special characteristics of respirations should always be assessed. The depth of a person's respirations can be established by watching the movement of the chest. Respiratory depth is generally described as normal, deep, or shallow. During a normal inspiration or expiration, an adult takes in about 500 ml of air. Body position also affects the amount of air that can be inhaled. Respiratory rhythm or pattern refers to the regularity of expirations and inspirations. Normally, respirations are evenly spaced. Respiratory rhythm can be described as regular or irregular. An infant's respiratory rhythm may be less regular than an adult's. Respiratory