Procedure Guidelines for Obtaining Blood Pressure by the Two-Step Method

1. Verify the health care provider’s orders.
2. Gather the necessary equipment and supplies.
3. Perform hand hygiene.
4. Provide for the patient’s privacy.
5. Check the patient’s baseline reading, and determine the best site to use. For example, if the patient is receiving intravenous fluids in the left arm, use the right arm to take the blood pressure.
6. Introduce yourself to the patient and family if present. Identify the patient using two identifiers, such as name and date of birth or name and account number, according to agency policy. Compare these identifiers with the information on the patient’s identification bracelet.
7. With the patient supine or sitting, position the forearm at heart level and support it with the palm up. If sitting, have the patient keep his or her feet flat on the floor. Placement of the arm above heart level causes a falsely low reading of about 2 millimeters of mercury (mmHg) for each inch (2.5 cm) above heart level.
8. Expose the upper arm fully by removing any clothing that is in the way.
9. Ensure that you have the appropriate size blood pressure cuff for the patient. The cuff’s width should be 40% of the circumference of the midpoint of the limb on which it will be used. The cuff’s bladder should encircle at least 80% of the upper arm.
10. Palpate the patient’s brachial artery in the antecubital space.
11. Position the cuff 1 inch above the artery, with the cuff’s arrows centered over the artery. If the cuff does not have arrows, estimate the center of the bladder and place that over the artery. Then wrap the fully deflated cuff evenly and snugly around the upper arm.
12. Position the manometer vertically at eye level, and stand no more than 1 yard away from it.
13. Using the fingertips of your nondominant hand, palpate the brachial artery distal to the cuff while inflating the cuff with your other hand.
14. Note the point at which the pulse disappears, and continue to inflate the cuff 30 mmHg higher. Note that point, and then slowly deflate the cuff.
15. Note the point at which the pulse reappears. This is the palpated systolic pressure. The measurement is expressed in millimeters of mercury (mmHg).
16. Fully deflate the cuff and wait 30 seconds.
17. Clean the earpieces, diaphragm and bell of the stethoscope with alcohol swabs.
18. Place the stethoscope earpieces in your ears, following the angle of the ear canals. Ensure that the sounds are clear and not muffled.
19. After relocating the brachial artery, place the stethoscope’s bell or diaphragm chestpiece over it, but do not let the chestpiece touch the cuff or the patient’s clothing.
20. Close the valve on the pressure bulb by turning it clockwise until it is tight. Then quickly inflate the cuff 30 mmHg above the patient’s palpated systolic pressure.
21. Slowly release the valve on the pressure bulb, and let the manometer indicator fall 2 to 3 mmHg per second. Note the point on the manometer at which you hear the first clear sound. This is the first Korotkoff sound, which reflects the systolic pressure.

22. The sound will slowly increase in intensity. Continue to deflate the cuff slowly, and when the sound disappears, note the pressure to the nearest 2 mmHg. This is the fifth Korotkoff sound, which reflects the diastolic pressure.

23. Listen for 10 to 20 mmHg after the last sound, and then let the remaining air escape quickly. Discuss the findings with the patient. Remove the cuff.

24. For greater accuracy, take the patient’s blood pressure again in 2 minutes. Use the second set of measurements as the baseline.

25. Remove the cuff from the patient’s arm. If this is the first assessment, repeat the process on the other arm, if possible.

26. To complete the procedure, help the patient into a comfortable position, cover the upper arm again, and discuss your findings.

27. Perform hand hygiene.

28. Clean the earpieces, diaphragm, and bell of the stethoscope with alcohol swabs.

29. Compare your findings with the classification of blood pressure for adults:
   A. Normally, the systolic pressure is less than 120 mmHg, and the diastolic pressure is less than 80 mmHg.
   B. In prehypertension, the systolic pressure is 120 to 139 mmHg, and/or the diastolic pressure is 80 to 89 mmHg.
   C. In stage 1 hypertension, the systolic pressure is 140 to 159 mmHg, and/or the diastolic pressure is 90 to 99 mmHg.
   D. In stage 2 hypertension, the systolic pressure is 160 mmHg or higher, and/or the diastolic pressure is 100 mmHg or higher.

30. As part of your follow-up care, compare this BP measurement to the patient’s baseline readings.

31. Help the patient into a comfortable position, and place toiletries and personal items within reach.

32. Place the call light within easy reach, and make sure the patient knows how to use it to summon assistance.

33. To ensure the patient’s safety, raise the appropriate number of side rails and lower the bed to the lowest position.

34. Dispose of used supplies and equipment. Leave the patient’s room tidy.

35. Remove and dispose of gloves, if used. Perform hand hygiene.

36. Document and report the patient’s response and expected or unexpected outcomes.