BLOOD PRESSURE SCREENING
PROTOCOL AND GUIDELINES

Protocol
In accordance with the American Heart Association and the guidelines of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, the blood pressure screening will provide documentation, evaluation, referral and follow-up as needed for clients who participate in the screening.

Purpose
This will increase the communities knowledge and awareness regarding the incidence and prevalence of hypertension and how it adversely affects the health of individuals. It will actively decrease the incidence of heart attack, heart failure, stroke, and kidney disease through screening and referral. In addition, it will educate the community about lifestyle modifications that may prevent or treat high blood pressure.

Goals
- To measure each individual’s blood pressure
- To inform participants of their blood pressure reading and to reinforce its relationship to their overall health.
- To inform the participants of the need for regular blood pressure checks.
- To identify persons with elevated blood pressure readings and refer them for further evaluation.
- To provide ongoing monitoring and reinforce the importance of following the prescribed treatment plan for persons known to have hypertension and who are under treatment.
- To provide an ongoing record for each client that participates in screening.

Definition of Hypertension
Hypertension is sustained, elevated arterial blood pressure with three readings, taken on three separate occasions.

Guidelines for Blood Pressure (BP) Screening
1. Inspect blood pressure equipment (cuff, gauge, bladder, tubing, bulb, and valve) for any cracks or malfunctions. If cracks or malfunctions exist, do not use and discard.
2. Gather equipment (different sized BP cuffs, stethoscope, alcohol wipes, BP screening sign-in sheet, client individual participant record, educational handouts on display)
3. Gather and set-up equipment in a private and quiet location. Privacy folding screens may be used to set up separate individual stations.
4. Ask the client to read Blood Pressure Screening Sign-In information and sign.
5. Ask the client if currently they are taking blood pressure medication.
6. Ask the client if they have refrained from smoking or drinking caffeine for 30 minutes.
7. Clients should be seated comfortably for a few minutes with legs uncrossed and feet resting firmly on the floor with back supported.
8. Ask the client which arm they prefer to use (Do not take blood pressure on arm with dialysis fistula, lymph problems, mastectomy, or affected side from stroke).
9. Make sure the forearm is supported at the level of the heart. Ask client to roll up sleeve. If sleeve is too tight, it can cause an inaccurate reading. If client is willing, ask client to slip arm out of sleeve. Be sure to maintain privacy.
11. Choose an appropriate sized cuff. The bladder within the cuff should encircle at least 80% of the upper arm. The vertical lines on the inside of the cuff should overlap, if not use larger cuff. Record cuff size.
12. Center the bladder of the cuff over the brachial artery and wrap smoothly and snugly around arm.
13. Deflate cuff so that the pressure falls no faster than 22mmHg per second. The first sound heard is the systolic pressure. The last sound heard is the diastolic pressure. If sounds are heard all the way down to zero, record the point of “muffling” as the diastolic pressure.
14. Record the systolic blood pressure (SBP) and diastolic blood pressure (DBP).
15. If this is client’s first visit, take readings in both arms if there are no contraindications. Use arm with higher reading for subsequent readings. Readings may vary up to 20mmHg between arms.
16. Record the date, blood pressure and arm that was used. Ex: 1/6/13: BP 130/78 LA (Left Arm). Record on the individual record and on a Client Handout. Give the Client Handout to the client to encourage self responsibility.
17. Explain the meaning of the blood pressure reading.
18. Advise the need for remeasurement or referral within the stages of the hypertension.
19. Provide information and educational materials as needed. Give encouragement.
20. Seek medical attention for unusually low readings. Client’s doctor should evaluate.

**Point of Emphasis**
If a client has severely elevated blood pressure and/or presents with severe headache, confusion, dizziness, blurred vision, facial drooping, slurred speech, numbness in face, arm or leg, trouble walking, chest pain or shortness of breath, the nurse will call 911 immediately for ambulance transport.

### National Institute of Health Guidelines and Recommendations 2003

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Normal</th>
<th>Prehypertensive</th>
<th>HTN Stage I</th>
<th>HTN Stage II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic</td>
<td>&lt;120</td>
<td>120 - 139</td>
<td>140 - 159</td>
<td>&gt;/ = 160</td>
</tr>
<tr>
<td>Diastolic</td>
<td>&lt;80</td>
<td>80 - 89</td>
<td>90 - 99</td>
<td>&gt;/ = 100</td>
</tr>
</tbody>
</table>

#### Recommendations
- Normal – Recheck blood pressure regularly. Healthy lifestyle encouraged.
- Pre-hypertension – Recheck blood pressure regularly and begin lifestyle modifications.
- Hypertension Stage I – See healthcare provider **within 30 days** to recheck.
- Hypertension Stage II – See healthcare provider **within one week** to recheck.
- If systolic and diastolic are in different categories, recommend **shorter follow-up** time, i.e., 160/86 should be referred to health care provider within one week to recheck.
- For higher pressure (> 180/110), seek medical attention **immediately**

Table from the National Institute of Health Guidelines and Recommendations 2003.

1/13 Alaska Faith Community Nurse Resource Center at Providence