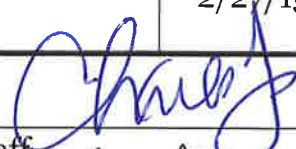
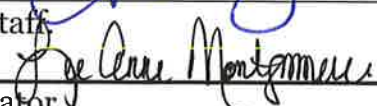


Crenshaw Community Hospital Policies and Procedures	Policy Number MS.500.170	Effective Date
	Revision Date 2/27/15	Review Date 2/27/15
Manual: Nursing	 Chief Of Staff  Administrator.	
Title: Vital Signs		

ASSESSING PATIENTS VITAL SIGNS

ROUTINE VITAL SIGNS

1. Vital signs (T, P, R, B/P, pain scale and SaO₂) will routinely be taken on all patients at 0800, 1200, 1600, and 2000, unless otherwise ordered by the physician.
2. Admission vital signs will include height and weight.
3. If the patient's vital signs are not within normal limits, they are to be taken more frequently as determined by the physician or RN in charge.
4. Any time a patient's condition changes, the vital signs are to be taken so they can be reported to the physician.
5. Vital signs will be charted on the patients "graphic chart.
6. Blood pressure, pulse and respiration taken more frequently than every two hours will be charted on the "Blood Pressure Graphic Sheet".
7. All entries on graphic sheets are to be dated and timed.
8. Vital signs on post-operative patients remain every fifteen minutes X4 then hourly X3 (if normal) upon return to room. These vital signs should be charted on the nurses notes as well as the "Blood Pressure Graphic Sheet" with other pertinent observations regarding the patient, e.g., level of consciousness, pain experienced, observations.

TEMPERATURE

Equipment:

Oral thermometer, probe covers, and electronic vital signs monitor.

Procedure: Oral Temperature

1. Wash hands.
2. Explain procedure to patient.
3. If using an electronic thermometer, place cover on probe.
4. Ask patient to open his mouth and place the thermometer under the tongue.
5. Ask patient to hold the thermometer with his lips. Leave the thermometer in place until thermometer beeps when complete.
6. Discard probe cover.
7. Wash hands.

8. Document Temperature.
9. Clean thermometer between using the recommended manufactures directions.

Equipment:

Rectal thermometer, soft tissue/napkin, probe cover and lubricant.

Procedure: Rectal Temperature

1. Wash hands.
2. Explain procedure to patient.
3. Assist patient to assume lateral position. Provide privacy before folding back bed linens to expose buttocks.
4. Place some lubricant on a piece of tissue. Then apply lubricant to thermometer. After placing probe cover on thermometer. For an infant, lubricate from 1/2 to 1 inch.
5. With one hand, raise the upper buttock to expose the anus. For the infant, hold both ankles by one hand and raise the legs to expose anus.
6. Insert thermometer into anus 1/2 to 1 1/2 inches, depending on age and size of patient. Do not force the insertion of thermometer.
7. Hold thermometer in place for 1-2 minutes or until the thermometer beeps.
8. Clean thermometer according to Manufactures recommendations between each use.
9. The thermometer may be used to take rectal temperatures. Use the red probe while taking a rectal temperature.
10. Document temperature.

PULSE

Purpose: Taking a Radial Pulse. Determine the pulse rate, obtain an estimate of the character (rhythm, quality) of pulse, aid in making patient observation of responses to medical/ nursing treatment.

Equipment:

Watch with second hand, paper and pen

Procedure:

1. Wash hands. Make certain patient is in a comfortable position, either sitting or lying down. Ask patient to remain quiet.
2. Provide support for patients arm. Turn palm down.
3. Use tips of first three fingers, locate radial artery and press gently against radius.
4. Count the number of pulsations (beats) for one minute, observe the quality, and any irregularities of the pulse.
5. Repeat the count if unsure of accuracy.
6. Document rate and observation.

Purpose: Taking an Apical – Radial Pulse. Determine if there is a pulse deficit.

Equipment:

Watch with a second hand, stethoscope, and paper and pen.

Procedure:

1. Wash hands.
2. Place finger tips near nipple (under the left breast of mature women) and locate the apex of the heart.
3. Place tips of stethoscope in your ears and the bell over the region of the patient's apex, listen for heart sounds.
4. Count the radial pulse and the heart beats, during exactly the same period of time, for one minute. Repeat counts for accuracy, and to not quality of pulse.
5. Document rates and observation.

RESPIRATIONS

Equipment:

Watch with second hand, paper and pen

Procedure:

1. Count respirations by watching the rise and fall of the chest as the patient breathes. Count respiration immediately after counting pulse, while fingers are still on wrist. Do not relax your fingers until finished.
2. Count each inhalation and exhalation as one respiration. Count for one full minute.
3. Document results. Notify RN Charge nurse or MD if less than 12 or greater than 30.

BLOOD PRESSURE

Blood Pressure using Dynamap

Purpose: An electronic vital signs monitor non- invasively and automatically registers systolic, diastolic and mean arterial pressure, heart rate and SAO₂.

Procedure:

1. Wash hands
2. Collect the necessary equipment: Blood pressure cuff that's 40% wider and 20% longer than the circumference of the arm or leg being monitored.
3. Explain the procedure to the patient. Describe the alarm system, so he/she won't be frightened if it's triggered.
4. Make sure the power switch is off. Then, plug the monitor into a properly grounded wall outlet.
5. Squeeze all air from the cuff, and loosely wrap it around the patients arm or leg, allowing 2 fingers between cuff and arm or leg. **Important:** Never apply the cuff to an arm or leg that has an IV line in place.
6. Place cuff on patient's arm or leg. Turn the monitor on.

7. To set the cuff inflation intervals, depress the appropriate add minute button to set for desired time.
8. If, at a later time, you need to record pressures without waiting for the next inflation, depress the NIBP button. The monitor will then inflate the cuff, display pressures and automatically return to its preset interval.
9. Document findings within the patient's Medical record.

Blood Pressure Manual

Purpose: Determine the arterial pressure of blood by measuring the systolic and diastolic arterial pressure.

Equipment:

Sphygmomanometer, stethoscope, and paper and pen.

Procedure:

1. Wash hands
2. Select a cuff with width appropriate to size of upper arm and age of patient.
3. Clean the ear tips of the stethoscope.
4. Make certain patient is sitting or lying in a comfortable position. Support the forearm of arm to be used at heart level with the palm of the hand turned up. Support the forearm on a flat surface, like a table top if the patient is sitting.
5. Remove sleeve from arm unless sleeve is loose enough to turn up to at least 5 inches above the elbow.
6. Make certain cuff is deflated entirely.
7. Wrap cuff evenly and securely around the upper arm with tubing toward upper side. Make sure the cuff is one inch above space at bend of elbow. Tuck end of cuff under edge of last turn.
8. Fasten hook of the gauge (dial) to an upper edge of the cuff, make certain gauge is placed for accurate reading.
9. Place ear tips of stethoscope into ears.
10. Close the valve on the rubber bulb.
11. Use finger tips to find strongest pulsation over the brachial artery and gently position the bell of stethoscope over this spot.
12. Squeeze the bulb quickly, inflate the cuff until pulsation of the artery can no longer be heard.
13. Keep eye on the dial.
14. Slowly open the valve on the rubber bulb.
15. Listen for the first sharp, clear rhythmic sound and note the number on the dial for the systolic pressure reading.
16. Allow the cuff to deflate slowly, listen for a sudden change in sound to a soft or muffled thump and note the number on the scale or dial for the diastolic pressure reading.
17. Open valve to expel all air in cuff.
18. Wait at least one minute before repeating process to check for accuracy, follow steps 7- 17.

19. Remove cuff from arm and fold or roll to place in case. Cleanse ear tips of stethoscope. Clean with alcohol prep.
20. Document findings in patient's Medical record.
21. Clean the cuff between patients with Sani-Wipes.

Blood Pressure Orthostatic

Due to conditions such as hemorrhagic shock, dehydration or drug therapy with antihypertensive agents, a patient's blood pressure may take longer than normal to stabilize when a patient is changed from a lying position to a standing or sitting position.

Equipment:

Sphygmomanometer, stethoscope, paper and pen.

Procedure:

1. Wash hands
2. Have patient in flat position in bed 5 minutes before taking blood pressure and apical pulse.
3. Have patient sit up at 90 degree angle and take blood pressure and apical pulse immediately. Question patient concerning change in equilibrium. Patient's condition or physician's order will determine whether or not the bed may be flat. **Note:** The patient may feel dizzy. Provide safety measures.
4. Have patient stand at bedside. Take blood pressure and apical pulse immediately. Question patient concerning change in equilibrium. A period of rest may be required between sitting and standing measurements. Standing pressure may be omitted, depending on patient's condition and/or physician's order.
5. Chart blood pressures and pulses on vital signs graphic sheet. Designate which readings were lying, sitting and standing. Method of charting orthostatic blood pressure on vital signs sheet. Also document date and time of findings.
6. Report to physician any systolic change greater than 10 mmHg or any diastolic change greater than 20 mmHg in lying, sitting or standing position. Report any apical pulse change greater than 20 beats per minute.

Pain Assessment

The American Pain Society (1999) recommends assessing for pain as the fifth vital sign. This means that you should ask patients to rate their pain intensity whenever you take a full set of vital signs (Berdine, 2002; Molony, Kobayashi, Holleran, et. al., 2005; Pasero, 1997; Pasero & McCaffery, 2010). This method has been adopted at CCH and will be done as follows:

- On admission to CCH
- Before and after each potentially painful procedure or treatment.
- Before you implement a pain management intervention, such as administering an analgesic drug a, and 30 minutes after intervention
- With each check of vital signs, if the pain is an actual or potential problem.

- When the patient complains of pain

The numerical rating scale (NRS) will be used to rate pain in adults at CCH. It is 0-10 scale. Zero indicates no pain at all, whereas a 10 indicates the worst possible pain. Patient must be able to choose a number from 0-10 to denote their level of pain.

The Wong-Baker FACES pain rating Scale will be used for children and cognitively impaired patients. The FACES scale uses simple illustrations of faces to depict various levels of pain. It requires no numerical or reading skill. The smiling face with 0 has no pain, face 2 has little pain, face 4 has little more pain, face 6 even more pain, face 8 whole lot of pain, face 10 worst pain imaginable. See attached FACES scale.

SaO₂ Monitoring

Purpose:

Monitor arterial blood oxygen saturation (SaO₂). SaO₂ reflects the percentage of hemoglobin molecules carrying oxygen. The normal value is 95% to 100%. Values less than 94% should be reported to the RN Charge nurse. Well-oxygenated hemoglobin and deoxygenated hemoglobin in the circulating red blood cells absorb light differently. Using a light-emitting diode (LED), the oximeter is able to detect this difference and calculate the percentage of oxygenated hemoglobin.

Equipment:

Pulse Oximetry finger probe attached to the Dynamap

Procedure:

1. Wash hands
2. Clean finger probe with Sani-Wipes between each use.
3. Place finger probe on patient's finger.
4. Turn on Dynamap.
5. Document results

PAIN MEASUREMENT SCALE

