



PRAIRIE ST. JOHN'S

POLICY/PROCEDURE

Title: Vital Signs	Issued By: Clinical Services Policy Number: TX.056 Date Issued: 4/97 Review Cycle Start Dates: 2/00, 4/02, 7/17/05 Date Approved by: Leadership - 2/7/00 Clinical Services Function – 5/06/02, 10/17/05 Medical Executive Committee - 4/20/00, 5/16/02, 1/19/06 Board of Trustees - 5/25/00, 5/16/02, 4/27/06
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Policy:

To monitor physical status of patients at Prairie St. John's.

To obtain vital signs by a licensed nurse or a Psychiatric Technician or CD Technician, or Needs Assessment staff who have been trained and whose competency has been validated.

To optionally use the automated vital signs machine.

Procedure:

- 1.0 Take Temperature, Pulse, Respirations (T.P.R.) and Blood Pressure (B/P) at the time of Needs Assessment and on admission to the patient care unit and as ordered by the physician.
- 1.1 Report any abnormal findings to the Registered Nurse, who reassesses the findings
 - 1.1.1 Abnormal findings are defined as, but not limited to:
 - 1.1.1.1 O₂ Saturation <90
 - 1.1.1.2 Age < 13
 - 1.1.1.2.1 Systolic B/P ≤70 or ≥130
 - 1.1.1.2.2 Diasystolic B/P ≤50 or ≥ 94
 - 1.1.1.2.3 Pulse ≤75 or ≥110 or any irregular pattern to pulsations
 - 1.1.1.2.4 Respirations < 12 or > 22
 - 1.1.1.2.5 Temperature of 99.5F
 - 1.1.1.3 Age >13
 - 1.1.1.3.1 Systolic B/P ≤90 or ≥140
 - 1.1.1.3.2 Diasystolic B/P ≤ 50 or ≥ 90
 - 1.1.1.3.3 Pulse ≤60 or ≥100 or any irregular pattern to pulsations
 - 1.1.1.3.4 Respirations <10 or >20
 - 1.1.1.3.5 Temperature of 99.5 F
 - 1.1.2 If abnormal findings were obtained by the automatic Vital signs machine, verify the findings by manual B/P and P readings by an RN.

- 1.1.3 Registered Nurse notifies the physician of the abnormal findings and any corresponding symptoms or complaints except when physician has been made aware of findings and is monitoring (i.e. temperature and already being treated for infection) UNLESS readings have worsened.

2.0 Temperature

- 2.1 Temperatures are taken with an electronic ear thermometer located in the nursing station or Needs Assessment.
 - 2.1.1 Remove probe from the base unit by lifting firmly near the release button.
 - 2.1.2 Note equivalence setting on display: CORE, REC, ORAL, CAL
 - 2.1.3 Select TYMPANIC by pressing MODE button (if TYMPANIC not already displayed).
 - 2.1.4 Place disposable cover on probe tip.
 - 2.1.5 Place probe in ear canal and seal opening.
 - 2.1.6 Press and release SCAN button.
 - 2.1.7 Remove probe from ear as soon as triple beep is heard and display flashes DONE
 - 2.1.8 Read temperature in display window.
 - 2.1.9 Press blue RELEASE button to discard probe cover. Discard into trash receptacle.
 - 2.1.10 Return probe to base unit for storage.

3.0 Pulse

- 3.1 Automated vital signs machine
 - 3.1.1 Obtain pulse by utilizing the procedure for SpO2 or B/P
- 3.2 Radial
 - 3.2.1 Locate area on wrist to thumb side of internal area of wrist.
 - 3.2.2 Press lightly with fingertips (never thumb) to detect a pulsation.
 - 3.2.3 Count pulsations for 30 seconds (if regular) and multiply by 2. Count for 1 full minute if irregular or any other abnormalities are detected. If patient has cardiac history, always take pulse for one full minute.
- 3.3 Apical (by licensed nurse only)
 - 3.3.1 Use stethoscope. Place on patient's chest directly down from left nipple area.
 - 3.3.2 Listen, count for one full minute.

4.0 Respirations

- 4.1 Count breaths by observing the rise and fall of the chest/stomach region with each breath for 30 seconds and multiply x 2 if any irregular pattern count for one full minute.

5.0 Blood Pressure

- 5.1 Select the proper size cuff
 - 5.1.1 Each cuff is marked with an appropriate age group for use
 - 5.1.2 When using an appropriate size cuff, and wrap it around the upper arm, and the edge of the cuff ends up in the area marked "range".
- 5.2 Wrap the cuff around the upper arm area. It is best to place the cuff on a bare arm. If patient is in isolation for infection, place cuff over clean gown on arm. Wrap the cuff snugly with room between the cuff and the arm for two fingers. Place the mark on the cuff marked "artery" over the inner aspect of the arm in the center. Check to ensure the hose is not twisted, kinked or compressed. The patient's arm should be relaxed and motion free during measurement.
- 5.3 Automatic Vital Signs Machine
 - 5.3.1 With power on, press the Blood Pressure Start/Stop button.
 - 5.3.2 When complete, the systolic, diastolic and pulse rate are displayed.
- 5.4 Manual Blood Pressure
 - 5.4.1 Place the patient in a comfortable position (supine or sitting) and support forearm at

heart level.

5.4.2 Place the appropriate size cuff as noted in 4.1

5.4.3 Palpate the brachial artery on inner aspect of arm and place stethoscope over the site.

5.4.4 Close air valve and inflate the cuff while auscultating the sound over the brachial artery. When the sound disappears, inflate 20 MM more. Deflate cuff at a slow steady rate 2mm per second or 2 mm per heart beat. Never stop between the systolic and diastolic readings or re-inflate cuff to recheck the systolic reading.

5.4.5 First heart sound heard is systolic

5.4.6 Take diastolic reading at the point where heart sounds no longer heard.

5.5 Orthostatic Blood Pressure

5.5.1 Ask the patient to sit for one minute

5.5.2 Take blood pressure and pulse in sitting position

5.5.3 Ask patient to stand for one minute

5.5.4 Repeat blood pressure and pulse

5.6 Clean stethoscope with alcohol after using on a patient who is in isolation with infection. Wipe blood pressure cuff with disinfectant cloth.

6.0 SpO2

6.1 Automatic Vital Signs Machine

6.1.1 Insert the patient's finger (preferably right or left index finger) completely into the sensor. Do not use the thumb. Do not attach to the same side of the blood pressure if being done simultaneously.

6.1.2 In appropriately 10 seconds, the reading will be displayed.

7.0 Document vital signs on Vital Signs form or Needs Assessment Tool in appropriate space noted on form.

Associated Forms:

TX.056.F01 Vital Signs Record