PURPOSE:

1. To determine the temperature, pulse, respiration and blood pressure readings of the patient.
2. To assess alterations/variations of vital signs to aid in treatment and plan of care.

PERSON RESPONSIBLE:

Registered Nurses, Nursing Attendants, Nursing Students under supervision of Riverside College Instructors

GENERAL GUIDELINES:

1 Vital signs of all admitted clients shall be taken every 4 hours or as ordered by the attending physicians.

2 Accurate recording of vital signs shall be done by the nurse or nursing attendants or midwives on duty or by nursing students under supervision by Riverside College Clinical Instructors.

- 2.1 Use blue/black ink for temperature, respiration, BP, weight, stool and urine recording.
- 2.2 Use red ink for pulse recording.

3 A drop in temperature shall be documented as a broken line from the last temperature reading and continuously to the next temperature reading.

4 The policy on two (2) patient identifiers shall be followed

PROCEDURE:

TEMPERATURE CHECKING:

1. Nurse-on-duty, Nursing attendant, Student Nurses performs hand hygiene before taking vital signs.
2. Nurse-on-duty, Nursing Attendant, Student Nurses prepares the equipment needed.
3. Nurse-on-duty, Nursing Attendant, Student Nurses explains procedure to patient.
4. Nurse-on-duty, Nursing Attendant, Student Nurses assists client in comfortable position that provides easy access to temperature site.

5. Nurse-on-duty, Nursing Attendant, Student Nurses puts the digital thermometer on the axilla of patient until it beeps and checks the number that appears on the screen.(Make sure that the axilla is dry for accurate reading.)
6. Nurse-on-duty, Nursing Attendant, Student Nurses records the temperature of patient to chart and note if patient have fever.
7. Nurse-on-duty, Nursing Attendant, Student Nurses performs hand hygiene after checking the temperature.
8. Nurse-on-duty refers if fever is noted.

RADIAL PULSE TAKING

1 Nurse-on-duty, Nursing Attendant, Student Nurses performs hand hygiene before taking vital signs.

2 Nurse-on-duty, Nursing Attendant, Student Nurses assists client to assume supine or sitting position.

2.1 If supine, place client's forearm straight along side or across lower chest or upper abdomen with wrist extended straight. If sitting, bend client's elbow 90 degrees and support lower arm on chair or on nurse's arm. Slightly flex the wrist with palm down.

3 Nurse-on-duty, Nursing Attendant, Student Nurses places tips of first two fingers of hand over groove along radial or thumb side of client's inner wrist.

4 Nurse-on-duty, Nursing Attendant, Student Nurses lightly compress against radius, obliterate pulse initially, and then relax pressure so pulse becomes easily palpable.

5 Nurse-on-duty, Nursing Attendant, Student Nurses determines strength of pulse. Note whether thrust of vessel against fingertips is bounding, strong, weak or thready.

6 After pulse can be felt regularly, Nurse-on-duty, Nursing Attendant, Student Nurses looks at the watch's second hand and begin to count the rate. When sweep hand hits number on the dial, start counting with zero, then one, two and so on.

7 Nurse-on-duty, Nursing Attendant, Student Nurses counts pulse rate for one full minute.

8 Nurse-on-duty, Nursing Attendant, Student Nurses records in the reminders notebook and graph in the TPR graphic sheet.

RESPIRATORY RATE TAKING

1. While still holding the patient's wrist, Nurse-on-duty, Nursing Attendant, Student Nurses takes note of breathing.
2. Nurse-on-duty, Nursing Attendant, Student Nurses makes sure that the client's chest is visible.
3. Nurse-on-duty, Nursing Attendant, Student Nurses observes complete respiratory cycle (one inspiration and one expiration).
4. While cycle is observed, Nurse-on-duty, Nursing Attendant, Student Nurses notes for the rhythm, depth and character of breathing.
5. Nurse-on-duty, Nursing Attendant, Student Nurses counts the number of respiration for one full minute.
6. Nurse-on-duty, Nursing Attendant, Student Nurses records the respiratory rate in TPR sheet.

BLOOD PRESSURE TAKING

1 Nurse-on-duty, Nursing Attendant, Student Nurses gathers equipment. Be sure that the cuff is appropriate for the client.

2 Nurse-on-duty, Nursing Attendant, Student Nurses performs hand hygiene.

3 Nurse-on-duty, Nursing Attendant, Student Nurses explains the procedure to the client.

4 Nurse-on-duty, Nursing Attendant, Student Nurses places client in a relaxed reclining or sitting position with arm at heart level.

5 Nurse-on-duty, Nursing Attendant, Student Nurses determines the best site for BP assessment. Avoid applying cuff to extremity when intravenous fluids are infusing; an arteriovenous shunt or fistula is present; breast or axillary surgery has been surgery has been performed on that side; extremity has been traumatized, diseased or requires a cast or bulky bandage. The lower extremities may be used when the brachial arteries are inaccessible.

6 Nurse-on-duty, Nursing Attendant, Student Nurses determines baseline Blood Pressure (if available) from client's record.

7 Nurse-on-duty, Nursing Attendant, Student Nurses explains to client that BP is to be assessed and have client rest at least 5 minutes before measurement. Ask client not to speak when BP is being measured.

7.1 With client sitting or lying, position client's forearm or thigh supported, if needed. For arm, turn palm up; for thigh, position with knee slightly flexed.

7.2 Expose extremity (arm or leg) fully by removing constricted clothing.

7.3 Palpate brachial artery (arm) or popliteal artery (leg). Position cuff 2.5 cm (1 inch) above site or pulsation (antecubital space or popliteal space).

7.4 Apply bladder of cuff above artery by centering arrows marked on cuff over artery. Wrap cuff evenly and snugly around extremity.

7.5 Position manometer vertically at eye level. Observer should be no farther than 1 meter (approximately 1 yard) away. If you do not know the client's baseline BP, estimate systolic pressure by palpating the artery distal to the cuff with fingertips of one hand while inflating cuff rapidly to pressure 30 mmHg above point at which pulse disappears. Slowly deflate cuff and note point when pulse reappears. Deflate cuff fully and wait 30 seconds.

8 Nurse-on-duty, Nursing Attendant, Student Nurses places stethoscope earpiece in ears and makes sure that the sound is clear, not muffled.

9 Nurse-on-duty, Nursing Attendant, Student Nurses locates brachial or popliteal artery and place bell or diaphragm chest piece of stethoscope over it. Do not allow chest piece to touch cuff or clothing.

10 Nurse-on-duty, Nursing Attendant, Student Nurses closes valve of pressure bulb clockwise until tight. Rapidly inflate cuff to 30mmHg above palpated systolic pressure.

11 Nurse-on-duty, Nursing Attendant, Student Nurses slowly releases pressure bulb valve and allow needle of aneroid manometer gauge to fall at rate of 2 to 3 mmHg/sec.

12 Nurse-on-duty, Nursing Attendant, Student Nurses notes point on manometer when first clear sound is heard. The sound will slowly increase in intensity.

13 Nurse-on-duty, Nursing Attendant, Student Nurses continue to deflate cuff, gradually, noting point at which muffled or dampened sound appears.

14 Nurse-on-duty, Nursing Attendant, Student Nurses continue to deflate cuff, gradually, noting point at which sound disappears in adults. Listen for 10 to 20 mmHg after the last sound, and then allow remaining air to escape quickly.

15 Nurse-on-duty, Nursing Attendant, Student Nurses removes cuff from extremity unless measurement must be repeated. If this is the first assessment of client, repeat procedure on other extremity.

16 Nurse-on-duty, Nursing Attendant, Student Nurses assists client in returning to comfortable position and cover upper arm if previously clothed.

17 Nurse-on-duty, Nursing Attendant, Student Nurses compares reading with previous baseline and/or acceptable value of blood pressure for client's age.

18 Nurse-on-duty, Nursing Attendant, Student Nurses compares blood pressure in both arms or both legs if there is any alterations.

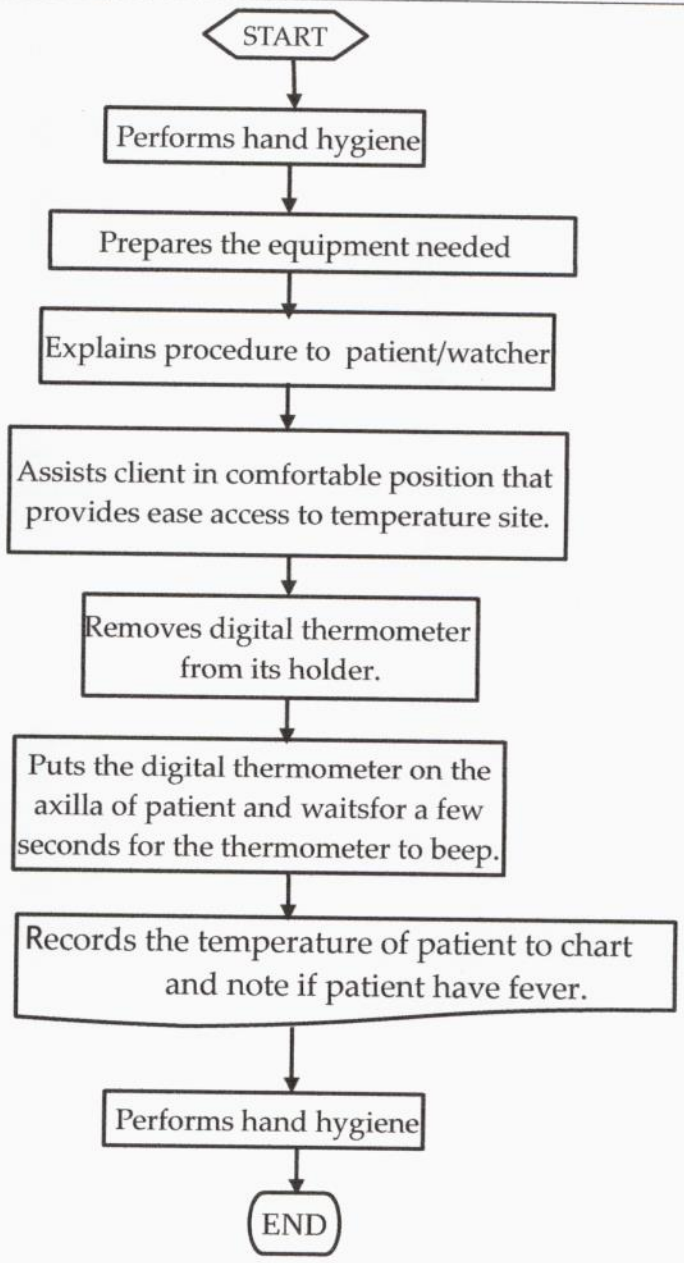
19 Nurse-on-duty, Nursing Attendant, Student Nurses performs hand hygiene.

20 Nurse-on-duty, Nursing Attendant, Student Nurses records blood pressure in TPR sheet.

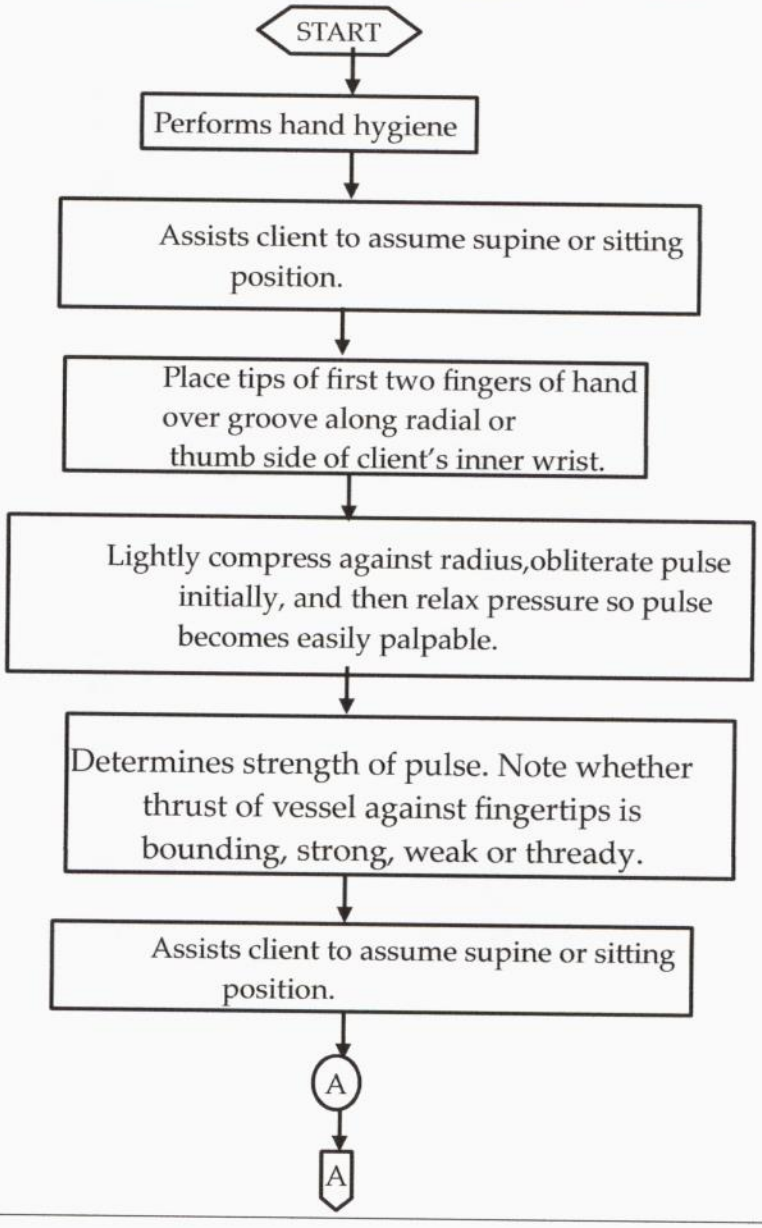
APPROVAL:

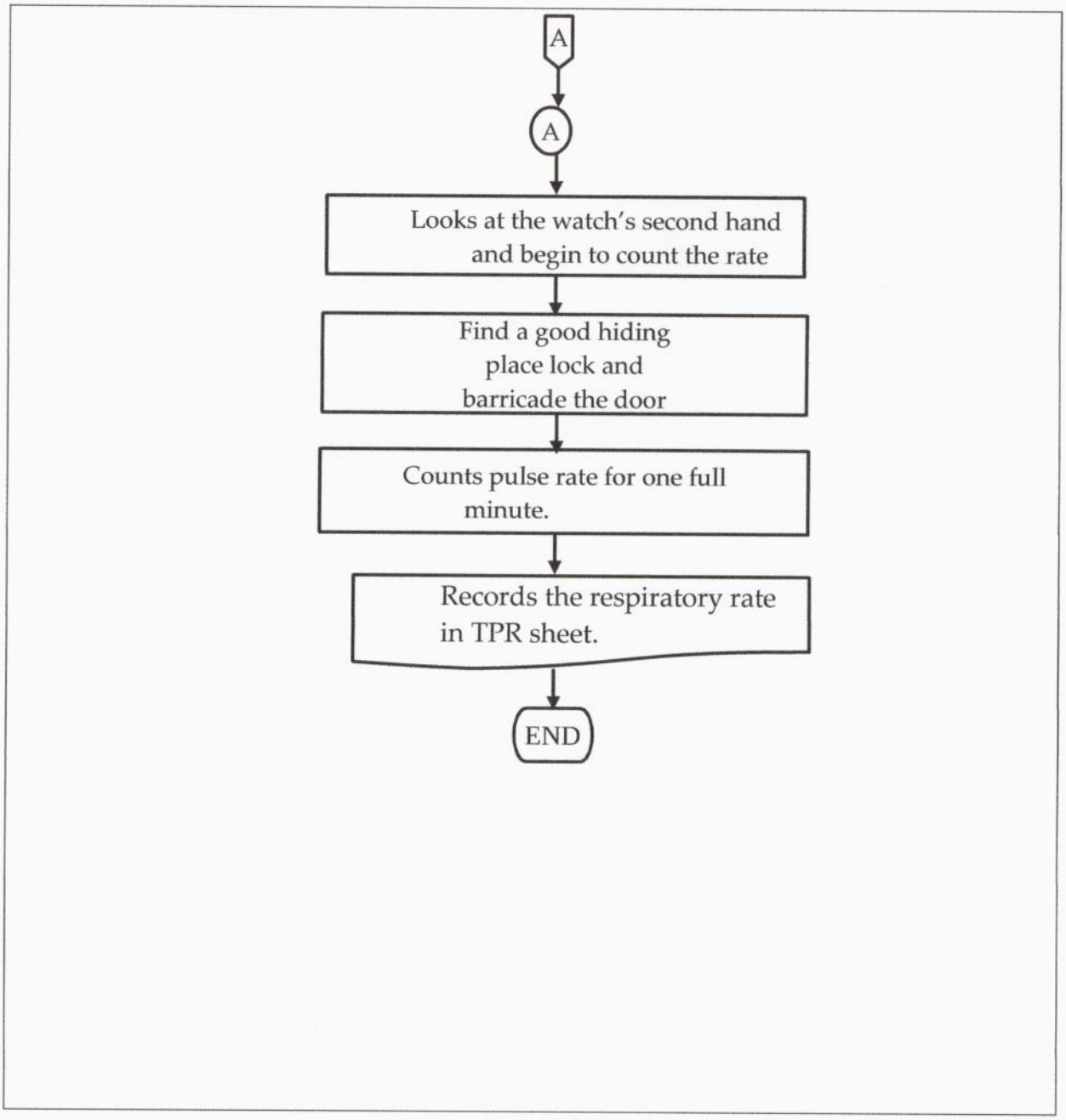
	Name/Title	Signature	Date
Prepared by:	**KAREN JOY GUMBAN, RN** Staff Nurse		5/31/2022
Verified by:	**RICHARD S. MONTILIJAO, RN** OIC-Policy Development		5/26/2022
	SHALAINE SOCORO L. DURAN, RN Nurse Manager for Operations		6/1/2022
	HANNAH KHAY S. TREYES, RN MN Chief Nurse		06/02/2022
Reviewed:	**DENNIS C. ESCALONA, MN, FPCHA, FPSQua** Quality Assurance Supervisor		06/02/2022
Recommending Approval:	**MARIA LIZA C. PERAREN, RN MAN** Nursing Division Officer		06/2/2022
	FREDERIC IVAN L. TING, MD OIC-Total Quality Division		6/10/22
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President – Chief Medical Officer		6-13-22
Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		6/23/22

FLOWCHART (TEMPERATURE TAKING)

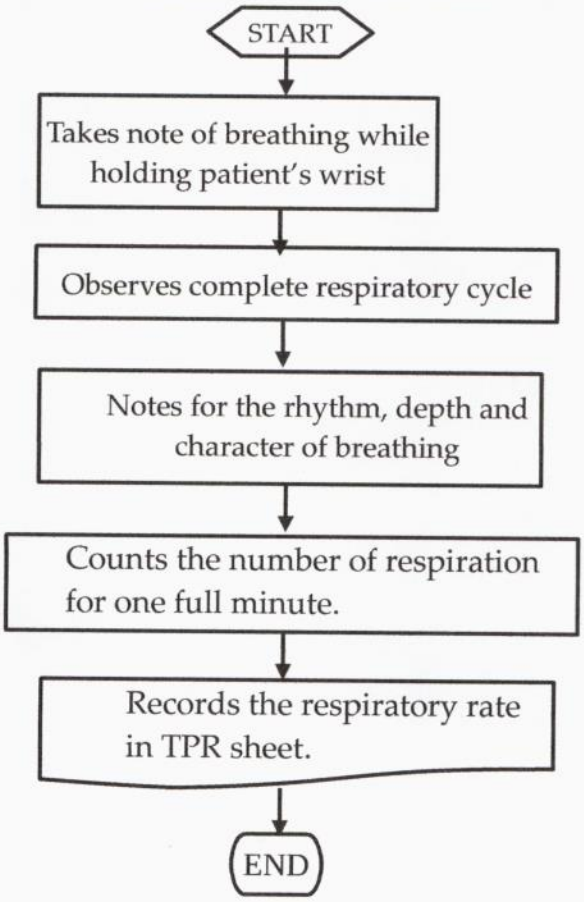


FLOWCHART (RADIAL PULSE TAKING)

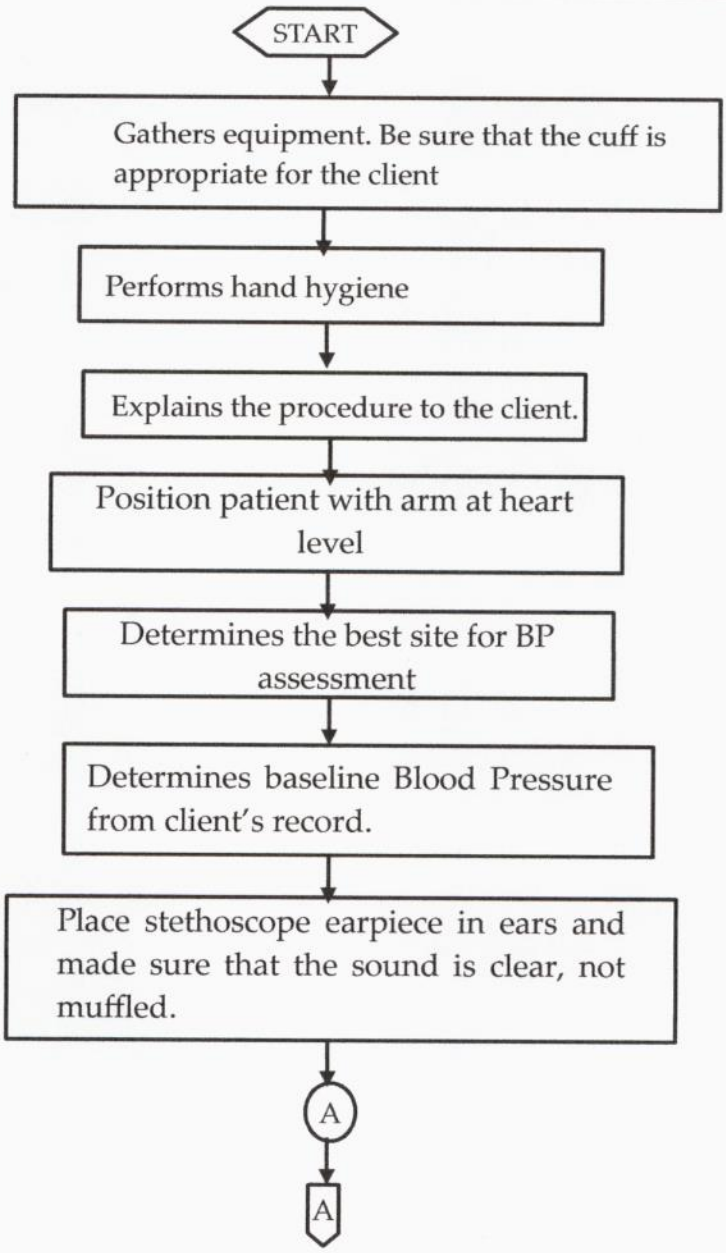


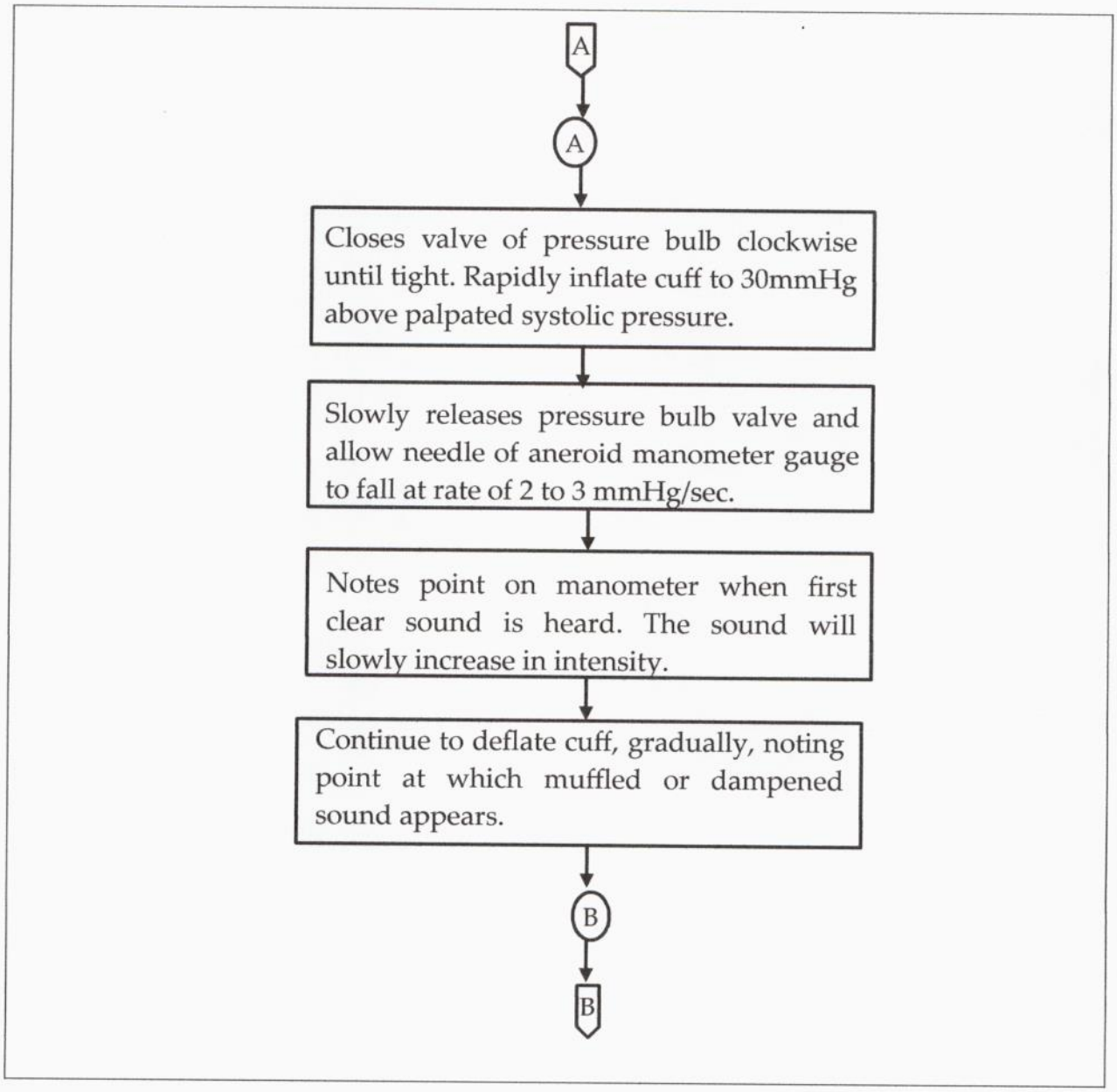


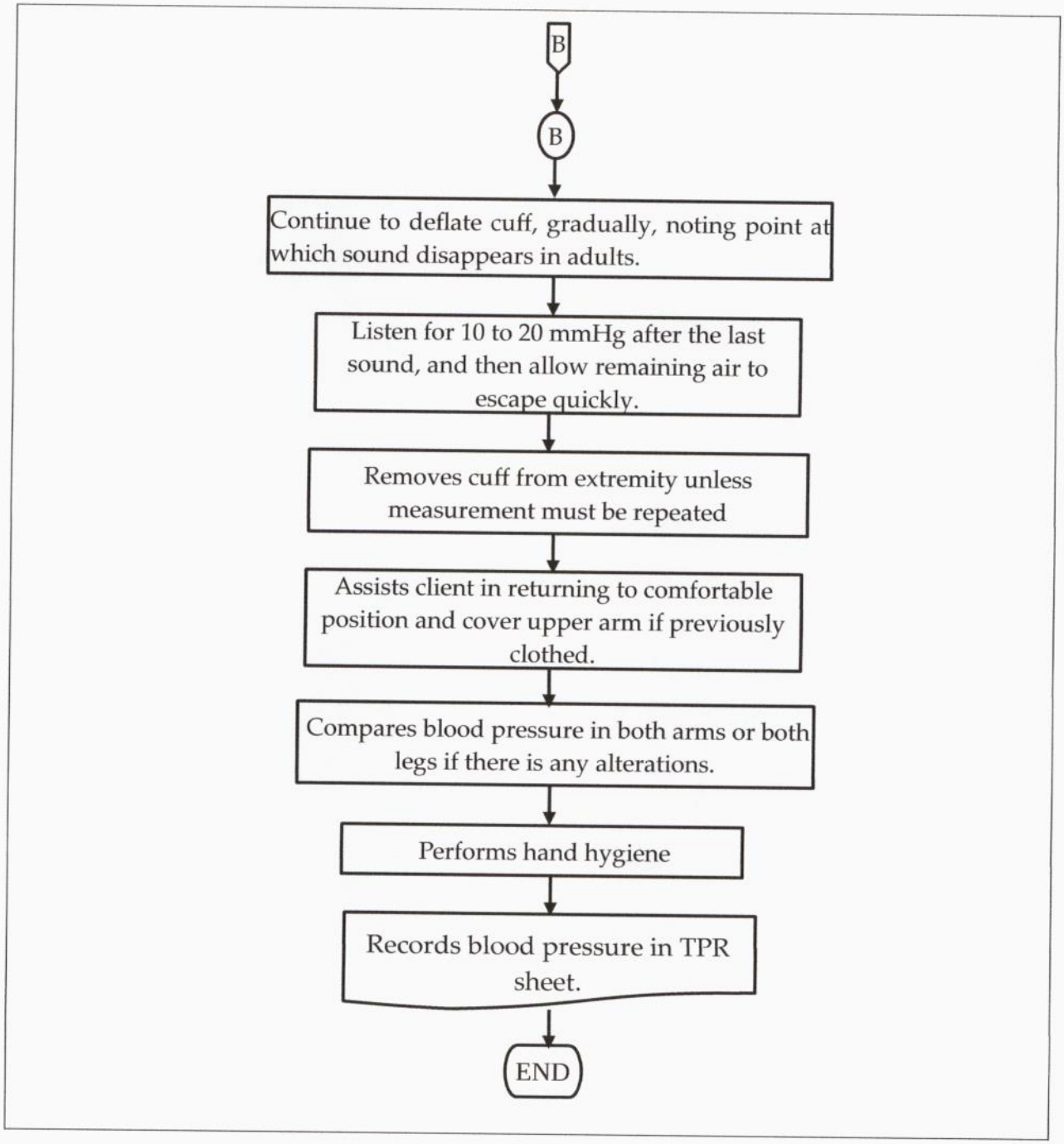
FLOWCHART (RESPIRATORY RATE TAKING)



FLOWCHART (BLOOD PRESSURE TAKING)







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Verified by:	**RICHARD S. MONTILIJAO, RN** OIC-Policy Development		5/26/2022
	SHALAINE SOCORO L. DURAN, RN Nurse Manager for Operations		6/1/2022
	HANNAH KHAY S. TREYES, RN MN Chief Nurse		06/02/2022
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Recommending Approval:	**MARIA LIZA C. PERAREN, RN MAN** Nursing Division Officer		06/02/22
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Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		6/23/22

KEY TASKS	PERSON RESPONSIBLE
1. Monitors vital signs every 4 hours or as ordered by the Physician.	Nurse-on-duty
2. Refers any alteration in vital signs.	
3. Monitors vital signs every 4 hours or as ordered by the Physician.	Nursing Attendants
4. Monitors vital signs every 4 hours or as ordered by the Physician.	Nursing Students under supervision of Riverside College Instructors

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Prepared by:	**KAREN JOY GUMBAN, RN** Staff Nurse		5/31/2022
Verified by:	**RICHARD S. MONTILIJAO, RN** OIC-Policy Development		5/26/2022
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Reviewed:	**DENNIS C. ESCALONA, MN, FPCHA, FPSQua** Quality Assurance Supervisor		06/02/2022
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