

WHITING FORENSIC HOSPITAL
Nursing Policy and Procedure Manual

SECTION D: PHYSIOLOGICAL ADAPTATION
CHAPTER 16: PHYSICAL ASSESSMENT

Policy and Procedure 16.1: Vital Signs Notification

Standard of Practice:

Nursing staff will accurately monitor and document patient's Vital Signs.

Standard of Care:

The patient can expect that his/her vital signs will be taken routinely and accurately by nursing staff. The patient's vital signs will be documented by nursing staff and assessed by a Registered Nurse.

Policy:

To set guidelines for notification of the Ambulatory Care Services (ACS) Clinician when patient vital signs are outside of the accepted norm. This will be the standard for all three divisions within Whiting Forensic Hospital. Parameters are to be established for temperature, blood pressure, pulse, respiration, and oxygen saturation. Regardless of vital signs, if the patient appears acutely medically ill, the ACS Clinician should be notified. Whenever a patient refuses any nursing intervention related to the monitoring of vital signs or weight, a second attempt to obtain the ordered intervention will be made within 24 hours and documented in a Progress Note. If the second attempt is not successful, the ACS Clinician will be notified for further orders. Ongoing refusals of care need to be reflected in the Treatment Plan with specific engagement interventions identified.

Procedure:

Vital signs will be done at least monthly (Temperature, Blood pressure, Heart rate, Respirations, Oxygen saturation, Weight) unless otherwise clinically indicated or as prescribed by the ACS Clinician.

A. Temperature:

1. A temperature of 100.5F will be the standard by which the ACS Clinician is notified.
2. If other signs and symptoms of fever are present, these should be reported at this time.
3. Actual fever occurs at a temperature of 100.4F.

B. Blood Pressure:

1. Blood pressure of below 90/60 or above 180/110 or significant changes from the patient's baseline is the standard by which the ACS Clinician is notified.
2. When taking the Blood Pressure, the following items need to be observed:
 - a. Cuff size needs to fit the patient by covering the limb.
 - b. If cuff is too small, the reading will be too high.
 - c. If cuff is too large, the reading will be too low.

C. Orthostatic Vital Signs:

1. Patient blood pressure and pulse should be checked in the supine, sitting and standing position. Wait for at least two minutes between position changes. If patient is unable to stand, sitting may be acceptable with feet dangling to the floor. A drop of up to 10 points in both systolic and diastolic blood pressure in the erect position is considered normal, or a drop of 10 beats per minute in heart rate.
2. Reference *Nursing Referencing Plus* permalink below for additional information.
3. After a patient fall, the RN will implement the nursing measure of orthostatic vital sign checks every four hours for a full twenty-four hours. The RN will notify the ACS Clinician of notable findings.

D. Pulse:

1. A pulse of greater than 110 beats per minute or less than 60 beats per minute is the standard by which the ACS Clinician is notified. The pulse is to be taken either by the Radial or Apical method. Pulse is to be counted 15-30 seconds or one full minute if irregular.
2. A normal pulse range is 60-80 beats per minute with an average of 70 beats per minute.

E. Respirations:

1. Respiration of less than 12 breaths per minute or greater than 26 breaths per minute or significant changes from the patient's baseline is the standard by which the ACS Provider is notified. Observe the chest rising and falling for one full minute.

F. Oxygen saturation:

If the oxygen saturation is less than 92%, the ACS Clinician is to be notified and/or when below the parameters identified by the ACS Clinician. This will be the standard for oxygen saturation. Normal Oxygen saturation is 97%-100%.

G. Weights:

1. Monthly weights will be completed on second shift.

Documentation:

Vital sign results falling outside the expected range will be so noted by the RN in an Integrated Progress Note.