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| **XYZ Health Network** | *NUR-ED-V-001* |
| **Title: Measurement of Vital Signs in the Emergency Department** | **Policy #:** |
| **Distribution: Acute care nursing** | **Policy Date:**5/2017 | **Page****1 of 2** |
| **Department/Category: Emergency Department** |
| **Document Owner: Emergency Department Nurse Manager** | **Revision Date:** |
| **Approved by: Administration** | **Supersedes Policy # / Date:**NUR-V-001/ 3/31/2017 |
| **Reference:** [**www.cincinnatichildrens.org**](http://www.cincinnatichildrens.org/) **Normal Pediatric Vital Signs, Emergency Medical Services****(2010)** |
| **KEYWORDS: Vital signs, ED** |

**I. GENERAL STATEMENT OF POLICY/PURPOSE**

EVERY patient will have vital signs measured during his/her Emergency Department (ED) visit. This includes temperature, pulse, respiratory rate (RR), blood pressure (BP), and, pulse oximetry (Pulse Ox).

**II. OBJECTIVES**

To provide clear direction on the initiation and completion of vital signs in the

Emergency Department.

**III. SCOPE AND RESPONSIBILITIES**

This policy/procedure applies to all Emergency Department Staff

**V. Procedures and Monitoring**

A. Vital signs will be measured and recorded every two (2) hours, or more frequently as clinically indicated by the RN or ED provider, and documented in picis.

B. Patients, who are to be discharged, will have vital signs repeated and recorded prior to discharge, including a pain assessment by an RN. Abnormal discharge vital signs will be reviewed with the medical provider prior to discharge.

C. Patients who are to be transferred out of facility to a higher level of care will have vital signs measured and recorded within 30 minutes to leaving the department.

Printed copies are for reference only. Please refer to the electronic copy of the document located on the Policy Tech System to ensure you are referring to the latest version. Electronic version is the controlled version.

D. Patients who are being transported out of the department for any reason (i.e. testing or admission) will have vital sings measured and recorded within 30 minutes of their departure excluding radiographs performed within the ED.

E. ALL vital signs outside of normal range will be reported immediately to the

Registered Nurse, Physician, and/or Physician assistant.

\*Abnormal Vital Sign Range for Adults 18 years or older: Pulse less than 60 or greater than 100

Respiratory Rate less than 12 or greater than 22

Systolic blood pressure less than 100 or greater than 160

Diastolic blood pressure less than 60 or greater than 90

Pulse Oximetry less than 92%

\*Abnormal vital sign range for Pediatric Patients < 18 years of age:

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|  | **Infant****0-12 months** | **Toddler****1-3 years** | **Children/Adolescent****6-14 years** |
| Pulse | Less than 100 orgreater than 170 | Less than 75 orgreater than 130 | Less than 70 orgreater than 105 |
| RR | Less than 30 orgreater than 60 | Less than 24 orgreater than 32 | Less than 16 orgreater than 28 |
| SBP | Less than 60 orgreater than 110 | Less than 90 orgreater than 120 | Less than 100 orgreater than 140 |
| Temp (C) | Less than 36 orgreater than 38 | Less than 36 orgreater than 39 | Less than 36 orgreater than 38 |
| Temp (F) | Less than 96.8 orgreater than 100.4 | Less than 96.8 orgreater than 102.2 | Less than 96.8 orgreater than 102 |
| Pulse Ox | Less than 95% | Less than 95% | Less than 95% |

**VI. DEPARTMENTAL REVIEW**

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|  | Emergency Department NurseManager | Date: 5/2017 |  |
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**VII. REVIEW**

This policy and procedure will be reviewed every two years.

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