I. PURPOSE:

To promote safety and continuity of patient care and to promote rapid recognition of changes in the patient’s condition.

II. RESPONSIBILITY:

All Patient Care Providers

III. POLICY:

A. Vital signs are defined as temperature, pulse, respiration & blood pressure. Some units may also include O₂ saturation, and ETCO₂, as per department policy, physician order, or as indicated by patient assessment. Vital signs are taken and then recorded for every patient throughout the facility. Routine vital signs are as follows:

1. Porter:
   a. PCU, Tele/Trauma, MSU, Stroke Unit, Oncology: every 4 hours
   b. Med/Surg: every 8 hours
   c. 5 West BMS: 0700
   d. RCU: 0700-1500-1930

2. HealthPlex:
   a. Ortho/Spine, PCCU: every 4 hours
   b. Women's & Children's (adults), Labor/Delivery/Postpartum: every 8 hours
   c. Women's & Children's (Pediatrics): every 4 hours
   d. Nursery: every 8 hours

B. Other units take vital signs per the specific unit policy:

1. ICU, CVICU: As per Critical Care policy CC 115
2. NICU: As per NICU policy NICU 20, NICU 21, NICU 22
3. SDS: As per Same Day Surgery policy SDS-167,
4. ENDO: As per ENDO policy ENDO 134
5. PACU: As per PACU policy PACU 200
C. Physician orders, procedural guidelines, and changes in patient condition are to take precedence over routine vital signs.

D. Vital Signs are to be documented as close to real time (time when measurements are taken) as possible. Generally, vital signs are documented within one hour of collection.

E. Nursing/Unit Assistants report abnormal vital signs to the RN as quickly as possible following collection. It remains the RN’s responsibility to ensure vital signs are taken and abnormal values reported appropriately.

IV. PROCEDURE:

V. REFERENCES:

Department Specific Policies:
- CC 115
- NICU 20, NICU 21, NICU 22
- SDS-167, SDS-120, SDS-115
- ENDO 134
- PACU 200

PCM 105 Assessment, Inpatient
PCM 5550 Postoperative/Post-Procedural Care

The Joint Commission Provision of Care: 01.02.01