Documentation of Vital Signs

Standard:

Vital signs are a required element of any patient evaluation. Complete sets of vital signs are to be documented for any patient who receives an assessment; or, documentation should describe why vitals could not be obtained. At minimum, the standard is to obtain an initial set of vital signs and at-least another set prior to patient disposition; be it a refusal of care, discharge by EMS, or arrival at a healthcare facility.

Purpose:

To insure that evaluation of every patient's volume, cardiovascular and mental status are documented with a complete set of vital signs.

Application:

1. Initial vital signs will be obtained manually with subsequent vital signs obtained electronically as long as they correlate with the manual vital signs. If there is a discrepancy, manual vital signs should be continued. Initial vital signs may be deferred until transport in severe trauma when other treatments and packaging may take priority and vital signs may interfere with the timely execution of these priorities.
2. An initial complete set of vital signs includes:
   - Peripheral or central pulse rate
   - Systolic AND diastolic blood pressure
   - Respiratory rate
   - Pain / severity (pain scale used & score), how pain was treated and response to treatments with pain scale.
   - Cumulative GCS score with individual sub scores.
   - Body temperature
3. Palpated blood pressures may be acceptable for **repeat** vital signs for patients not requiring medication administration or perfusion monitoring
4. Based on patient condition and complaint, vital signs may also include:
   - Pulse Oximetry
   - End Tidal CO2
   - Electrical heart rate from cardiac monitoring
5. If the patient refuses vital signs, document the refusal in the PCR in accordance with the Refusal of Treatment or Transportation Standard (Clinical Standard on Refusal of Treatment and/or Transport).
6. When any components of vital signs were obtained using the cardiac monitor, the data should be exported electronically to the electronic patient care report. Where values are inconsistent with manually obtained values, values may be appropriately edited to reflect the manually obtained values and accounted for in the narrative.
7. The mechanical pulse rate should be obtained through palpation.
8. Record the time all vital signs were obtained.
9. Any abnormal vital sign should be repeated and monitored closely.
10. Vital signs should be obtained approximately every 10 minutes. The provider should change the frequency as need to appropriately care for the patient.
11. An initial set of vital signs is obtained once the patient consents to treatment and can be accessed.