

**UC Riverside, School of Medicine Policies and Procedures****Policy Title:** Vital Sign Measurements and Recordings**Policy Number:** 950-03-013

<b>Responsible Officer:</b>	Director, Ambulatory Operations
<b>Responsible Office:</b>	Clinic Operations
<b>Origination Date:</b>	03/01/2016
<b>Date of Revision:</b>	08/4/2023
<b>Scope:</b>	UCR Health Clinics

**I. Policy Summary**

Vital sign assessment is essential in the determination of a patient's health status. Careful measurement techniques and knowledge of the normal range in vital signs for a particular patient will ensure that patients at UCR Health are suitably evaluated and will enable clinicians to carefully monitor therapy and prevent adverse events. Medical office staff will measure and record the patient's vital signs at every medical visit.

**II. Policy Text**

UCR Health is committed to providing the highest quality care and assessment of patients. Assessing, measuring, and monitoring patient vital signs are essential to ensure appropriate care is provided. Medical office staff is expected to take vital signs of each patient that will be seen by a provider. Vital signs are used to establish a baseline and to determine whether it is necessary for the provider to assess specific body systems more thoroughly.

**III. Responsibilities**

All UCR Health Clinical staff

**IV. Procedures****A. Before beginning any procedure:**

1. Have equipment clean and ready
2. Wash hands
3. Identify the person
4. Introduce yourself if necessary
5. Go to a private or quiet area
6. Explain the procedure
7. Document your results

**B. Temperature**

Oral electronic thermometers are easily accessible and require no position changes. The oral electronic thermometer is comfortable for patients. Explain route to patient on how temperature will be taken. Place disposable probe cover over thermometer probe stem and snap in place. Ask patient to open mouth then gently place probe under tongue in posterior sublingual pocket. Ask patient to hold thermometer probe with lips closed. Leave thermometer in place until audible signal indicates

completion and patient's temperature appears on digital display. Remove probe from patient's mouth. Push ejection button to discard probe cover from probe stem in appropriate trash container.

**C. Pulse**

Explain to patient that you will assess pulse by taking patient's wrist and locate pulse by placing tips of first two fingers of your hand over groove along radial or thumb side of patient's inner wrist. Lightly compress the pulse against radius, losing the pulse initially, and then relax pressure so pulse becomes easily palpable. Count rate for 30 seconds, if pulse is regular. If pulse is irregular, count pulse rate for 60 seconds.

**D. Respirations**

Be sure that patient's chest is visible. Observe one complete respiratory cycle (one inspiration and one expiration). If rhythm is regular, count number of respiration in 30 seconds and multiply by 2. If rhythm is irregular count for 1 full minute.

**E. Blood pressure**

Explain to patient that you will take blood pressure. A sphygmomanometer includes a pressure manometer, an occlusive cloth or vinyl cuff that contains an inflatable rubber bladder and a pressure bulb with a release valve that inflates the bladder. The manometer has a glass enclosed gauge containing a needle that registers millimeter calibration. Select appropriate size cuff. The inflatable bladder should encircle at least 80% of the arm. The cuff should be at least 40% greater than the arm circumference. Have patient in sitting position. Position patient's forearm with palm turned up. Keep patient's feet flat on floor without legs crossed. Remove any constricting clothing. Palpate brachial artery. With cuff fully deflated. Apply bladder of cuff above artery. By centering arrows marked on cuffs over artery. Position cuff 1 inch above site of pulsation. With cuff fully deflated, wrap cuff evenly and snugly around extremity. Place stethoscope earpiece in ears. Close valve of pressure bulb. Quickly inflate cuff to 30 mm Hg above patient's estimated systolic pressure. Slowly release pressure bulb valve and allow manometer needle to fall at rate of 2 to 3 mm Hg/sec. Note point on manometer when the first clear sound is heard. Continue to deflate cuff gradually, noting point at which sound disappears. Listen for 20 to 30 mm Hg after last sound, and then allow remaining air to escape quickly. Remove cuff from patient's arm, Record results.

**V. Related Information**

- A.** The usual adult temperature range is 96.4 to 99.4 degrees Fahrenheit. Fever is an elevation of body temperature beyond the normal range. Causes may be viral or bacterial infection, drug reaction, brain lesion, or reaction to other body pathology.
- B.** Blood pressure is influenced by problems with cardiac output and peripheral resistance. Hypertension occurs when the arterial pressure is significantly above average for the person involved. The average range for adult blood pressure is 90/70 to 128/88.
- C.** The pulse is a palpable bounding of blood flow caused by pressure wave transmission from the left ventricle of the heart to the peripheral arteries. Assessing the pulse provides indications of heart function and tissue perfusion. The pulse is easily palpable, regular in rhyme, and ranges from 60 to 100 beats per minute.
- D.** Respiration involves evaluating the exchange of oxygen and carbon dioxide between the environment, the blood, and cells. Rate refers to the number of times a person breathes in and out in one minute.

**VI. Related Policies or Clinical Protocols**

P001 Confirmatory BP reading 2023

**VII. Revision History**

New 3/2016

Revised 5/2019, 8/2023

**Approvals:**

**COMPLIANCE COMMITTEE (09/01/2023)**

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