Standard Operating Procedure (SOP): Patient Assessment and Vital Sign Documentation

This SOP describes the process for **patient assessment and vital sign documentation**, including initial patient evaluation, measurement of vital signs such as temperature, pulse, respiration, and blood pressure, accurate recording of findings, monitoring for changes, and proper communication of results to healthcare team members. The purpose is to ensure consistent, accurate, and timely assessment to support effective clinical decision-making and patient care.

1. Purpose

To establish a standardized process for conducting patient assessments and documenting vital signs to ensure accuracy, improve patient safety, and facilitate effective clinical decision-making.

2. Scope

This SOP applies to all healthcare staff responsible for patient assessment and documentation of vital signs in clinical settings.

3. Responsibilities

- Healthcare Professionals: Perform patient assessments, measure and record vital signs accurately, and communicate findings promptly.
- Supervisors/Team Leads: Ensure staff competency and compliance with this SOP.

4. Procedure

1. **Preparation**
    - Verify patient identity using two identifiers (e.g., name and DOB).
    - Introduce yourself and explain the procedure.
    - Wash hands and assemble necessary equipment.
2. **Initial Patient Assessment**
    - Assess level of consciousness, appearance, and general condition.
    - Note any immediate concerns or distress.
3. **Measurement of Vital Signs**
    - **Temperature:** Measure using appropriate device (oral, tympanic, etc.).
    - **Pulse:** Assess rate, rhythm, and strength at radial or other appropriate site.
    - **Respiration:** Observe rate, depth, and pattern.
    - **Blood Pressure:** Measure using calibrated sphygmomanometer.
4. **Documentation**
    - Record findings immediately and accurately in the patient's health record (paper or electronic).
    - Note time and method of measurement for each vital sign.
    - Document any deviations or abnormal findings and actions taken.
5. **Monitoring and Communication**
    - Monitor for any changes in patient condition and reassess as required.
    - Communicate abnormal findings or concerns promptly to the appropriate healthcare provider.

5. Documentation Template Example

Date/Time	Temperature	Pulse	Respiration	Blood Pressure	Observations/Remarks	Initials
2024-06-15 09:00 AM	37.2Â°C (oral)	78 bpm	16/min	120/80 mmHg	Patient alert and oriented. No distress.	AB

6. References

- Hospital Policy on Patient Assessment
- Best Practice Guidelines, [National/International Nursing Organization]

7. Revision History

Version	Date	Description	Author
1.0	2024-06-15	Initial SOP release	Quality Team