SOP Template: Initial Assessment and Vital Signs Monitoring Guidelines

Purpose:
This SOP provides detailed **initial assessment and vital signs monitoring guidelines**, covering procedures for promptly evaluating patients' condition, accurately measuring vital signs such as heart rate, blood pressure, respiratory rate, and temperature, and documenting findings. The guidelines emphasize the importance of timely assessment to identify critical health issues, ensure patient safety, and facilitate appropriate medical intervention.

1. Scope

This SOP applies to all healthcare personnel responsible for patient assessment and monitoring across all clinical care areas.

2. Responsibilities

- Registered Nurses (RNs): Perform initial assessment and vital signs monitoring as outlined.
- Physicians: Review findings, intervene as necessary, and provide guidance.
- Allied Health Staff: Assist as required and escalate concerns.

3. Procedure

3.1 Initial Assessment

- Greet the patient, confirm identity using at least two identifiers (e.g., name and date of birth).
- Assess the patient's general appearance, consciousness level (AVPU/Glasgow Coma Scale), and immediate clinical needs.
- Obtain a brief history of presenting complaint, allergies, medical history, and current medications.

3.2 Vital Signs Measurement

Vital Sign	Method/Device	Frequency	Normal Ranges (Adults)
Heart Rate (HR)	Palpate radial pulse / Use electronic monitor	On admission, every 4-6 hours or as clinically indicated	60-100 beats/min
Blood Pressure (BP)	Sphygmomanometer / Electronic monitor	On admission, every 4-6 hours or as clinically indicated	90/60 - 120/80 mmHg
Respiratory Rate (RR)	Observation of chest rise for 1 minute	On admission, every 4-6 hours or as clinically indicated	12-20 breaths/min
Temperature	Digital thermometer (oral/axillary/tympanic/temporal)	On admission, every 4-6 hours or as clinically indicated	36.0-37.5 Â°C (96.8-99.5 Â°F)
Oxygen Saturation (SpOâ,,)	Pulse oximeter	On admission, monitor if respiratory symptoms present	â‰¥ 95%

- Record all readings promptly in the patient's chart or electronic medical record (EMR).
- Use standardized forms/documentation tools.
- Repeat measurements if abnormal values are detected and escalate as needed.

4. Escalation Criteria

- Heart rate <50 or >120 beats/min
- Blood pressure <90/60 mmHg or >180/110 mmHg
- Respiratory rate <10 or >24 breaths/min
- Temperature <35Â°C or >38.5Â°C
- Oxygen saturation <94% (unless patient-specific targets apply)

- Altered level of consciousness

Immediate notification to physician and rapid response team as indicated.

5. Documentation

- Document all findings, time, and staff initials/e-signature.
- Note any interventions and patient responses.
- Follow organizational policy for digital or paper records.

6. References

- Institutional Clinical Assessment Policy
- World Health Organization: Vital Signs Measurement
- American Heart Association: Basic Life Support Manual