SOP Template: Initial Patient Assessments and Vital Sign Recording

> **PURPOSE:**
> This SOP details the process for **initial patient assessments and vital sign recording**, covering the methods for conducting a comprehensive evaluation of a patient's condition upon admission. It includes guidelines for measuring and documenting vital signs such as temperature, pulse, respiration rate, and blood pressure, ensuring accuracy and consistency. The purpose is to establish baseline health indicators, identify immediate medical needs, and support clinical decision-making for effective patient care.

1. Scope

This SOP applies to all clinical staff responsible for performing patient admissions and initial assessments in [Hospital/Clinic Name].

2. Responsibilities

- **Nurses:** Conduct and document initial assessments, measure, and record vital signs.
- **Physicians:** Review recorded vital signs and assessment data, initiate appropriate clinical actions as required.
- **Healthcare Assistants:** Assist in gathering equipment and supporting patients as needed.

3. Definitions

- **Vital Signs:** Key physiological measurements including temperature, pulse, respiration rate, and blood pressure.
- **Initial Assessment:** Comprehensive evaluation of patient's health status upon admission.

4. Procedure

1. **Preparation**
    - Gather required equipment: thermometer, sphygmomanometer, stethoscope, watch/timer, documentation tools (paper chart or EHR).
    - Perform hand hygiene and don appropriate personal protective equipment (PPE).
2. **Patient Identification and Introduction**
    - Verify patient identity using at least two identifiers (e.g., name, date of birth).
    - Explain the procedure to the patient and gain consent.
3. **Initial Assessment**
    - Assess and document patient's:
        - Chief complaint and presenting symptoms
        - Medical and surgical history
        - Allergies and medications
        - Mental status
4. **Vital Sign Measurement**
    - **Temperature:** Record using appropriate method (oral, tympanic, axillary, or rectal) and device. Note method used.
    - **Pulse:** Count for 30 seconds (if regular) or 60 seconds (if irregular). Note rate, rhythm, and strength.
    - **Respiration Rate:** Observe and count respirations for one minute. Note rate, rhythm, and character.
    - **Blood Pressure:** Use the correct cuff size and technique. Record systolic/diastolic values and arm used.
5. **Documentation**
    - Document all findings immediately in the patient's record, either on paper forms or electronic health record (EHR).
    - Report abnormal findings to the responsible physician without delay.

5. Documentation Requirements

Parameter	Details to Record
Temperature	Value, measurement method, time taken
Pulse	Rate, rhythm, strength, site, time taken
Respiration	Rate, rhythm, character, time taken
Blood Pressure	Values, arm used, position, time taken
Other Observations	Any deviations or relevant findings

6. References

- Hospital/Clinic Policy on Patient Admission & Assessment
- Local, regional, or national clinical guidelines

7. Review and Approval

This SOP shall be reviewed annually by the Clinical Governance Team and updated as necessary.