Standard Operating Procedure
Final Nursing Assessment and Vital Sign Documentation

Purpose

To describe the standardized process for conducting the **final nursing assessment and vital sign documentation** to ensure accurate evaluation of patient health status at the conclusion of care. This SOP ensures consistent, comprehensive assessment, accurate record-keeping, and effective communication among healthcare providers to promote optimal patient outcomes.

Scope

This SOP applies to all nursing staff responsible for performing final assessments and documenting vital signs prior to patient discharge, transfer, or at the end of nursing care episodes.

Responsibilities

- Registered Nurses (RNs): Perform final assessments, record findings, and communicate changes.
- Licensed Practical Nurses (LPNs) / Licensed Vocational Nurses (LVNs): Assist with assessment and documentation per local regulations and training.
- Nurse Supervisors: Ensure compliance and provide guidance.

Procedure

1. **Preparation**
    - Verify patient identity using two identifiers (e.g., full name and date of birth).
    - Explain the procedure to the patient to gain cooperation and address concerns.
    - Wash hands and assemble necessary equipment (thermometer, blood pressure cuff, stethoscope, watch with second hand, appropriate documentation tools).

2. **Assessment**
    - Conduct a focused, systematic nursing assessment, reviewing the patient's general condition and specific complaints.
    - Inspect, palpate, percuss, and auscultate as appropriate to the patient's condition.

3. **Vital Sign Measurement**
    - Temperature (route specified: oral, tympanic, axillary, or rectal as appropriate)
    - Pulse (rate, rhythm, and quality; location specified)
    - Respiration (rate, depth, and effort)
    - Blood pressure (with location and position noted)
    - Additional parameters as required (oxygen saturation, pain assessment, etc.)

4. **Documentation**
    - Accurately record all findings immediately after assessment in the patient's medical record (electronic or paper, as per facility policy).
    - Include date, time, and method of measurement.
    - Document any abnormal findings, actions taken, and notifications to other healthcare providers.
    - Sign or electronically authenticate the documentation.

5. **Communication**
    - Report significant assessment findings and abnormal vital signs to the provider per protocol.
    - Communicate the patient's readiness for discharge/transfer as indicated.

Documentation Example

Date/Time	Temperature	Pulse	Respiration	Blood Pressure	Comments/Assessment	Signature
2024-06-12 14:00	98.2Â°F (oral)	76 bpm	18/min	118/76 mm Hg (right arm, sitting)	Alert, oriented, no distress. Incision site clean and dry. No complaints of pain.	M. Nurse, RN

References

- Facility Policy: Patient Assessment and Documentation Guidelines
- State Nurse Practice Act
- Joint Commission Standards on Documentation and Communication

Review/Revision History

Effective Date: 2024-06-12
Next Review: 2026-06-12