What is the standard for frequency of measuring vital signs and performing physical assessments in critical care, progressive care, and telemetry units?

The frequency of measuring vital signs and performing physical assessments should be based on each patient’s needs rather than on specific time intervals. Furthermore, given the variability among patients, units, and institutions, no national standard can be set. Standards should be established by each facility on the basis of their unique populations of patients and should be determined by the clinical “experts” for that facility such as clinical nurse specialists, nurse managers, and nurse educators in collaboration with the other members of the multidisciplinary team. Other experts could be colleagues from community facilities and members of the local American Association of Critical-Care Nurses chapter. Simply stated, hospitals and nursing care units are at liberty to establish their own standards for assessment and documentation.

That being said, several key concepts should be considered when setting these standards. First, policies for frequency should set the minimum standard that meets the needs of the majority of patients in the clinical area while allowing opportunity for individualization based on a particular patient’s situation. In our facility, the critical care standard requires documentation of vital signs a minimum of every 2 hours. Frequently, however, vital signs are noted every 1 hour, and sometimes as often as every 5 to 15 minutes, depending on the patient’s condition. The individual characteristics of the patient as articulated in the American Association of Critical-Care Nurses Synergy Model—stability, complexity, predictability, vulnerability, and resiliency (see Table)—should serve as the framework for determining the frequency of assessment. Using this framework, patients who are at greatest risk for an adverse outcome (eg, patients with frequently changing physiological status, whose response to specific therapy requires close monitoring) should receive more frequent assessments.

In addition, the policy should also allow the nurse to individualize frequency of assessment on the basis of the patient’s medical diagnosis, comorbid conditions, types of treatments, and where the patient is in his or her hospital course. For example, a trauma patient newly admitted to the critical care unit requires more frequent assessment than does a patient who is ready to be discharged to the acute care area. As the patient’s condition improves,
interventions that require monitoring are reduced. The likelihood of changes in vital signs or fluctuations in clinical condition also decrease. Thus, the minimum standard should be set for the least prescriptive requirement while creating the expectation for more frequent assessment when needed.

A second key consideration is that assessment and documentation policies should not be so rigorous that they place unrealistic demands on nurses or fail to address the patient’s actual needs. Regulatory review groups such as The Joint Commission and state departments of health do not prescribe the exact frequency of assessment. Rather, they evaluate whether practice falls within an organization’s written policies. A standard that requires documentation of a full head-to-toe assessment every 2 hours in a critical care unit is probably an unreasonable burden and would be difficult to meet consistently. Alternatively, a more realistic standard would require that the minimum comprehensive assessment be supplemented by documentation of any changes in the patient’s status when those changes occur.

A third consideration is that the policy should allow for deviation from the standard based on the nurse’s judgment, with the expectation that the rationale for the variation will be documented in the patient’s record. The policy should provide flexibility to account for the reality of the experience of hospitalization (e.g., a patient could benefit from some much needed sleep rather than be disturbed for a complete assessment). On the basis of the patient’s stability, complexity, vulnerability, and predictability, a nurse may elect to assess only anterior breath sounds and skin temperature on a resting patient receiving mechanical ventilation or determine that a full assessment is indicated.

Finally, any differences between assessment standards and documentation standards must be clearly articulated. Assessment is not synonymous with documentation. A nurse may assess the patient with every interaction, but documentation does not necessarily need to be done with every interaction. Clearly describing what must be documented and the expected intervals for the documentation should establish

**Table** Framework for determining frequency of assessment based on characteristics of the patient as articulated in AACN’s Synergy Model

<table>
<thead>
<tr>
<th>Concept from Synergy Model</th>
<th>More frequent assessment</th>
<th>Less frequent assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stability</strong>&lt;br&gt;The ability to maintain a steady-state equilibrium</td>
<td>Patient admitted to intensive care unit with severe sepsis, who requires continuous or multiple bolus fluid administration or titration of vasoactive medications to achieve hemodynamic goals</td>
<td>Patient who does not require fluids or vasoactive medications to maintain blood pressure</td>
</tr>
<tr>
<td></td>
<td>Patient on progressive care unit with non-ST-segment elevation myocardial infarction immediately after cardiac intervention</td>
<td>Patient on progressive care unit admitted for observation of chest pain, no electrocardiographic changes, normal cardiac enzyme levels, requesting a good night’s rest</td>
</tr>
<tr>
<td><strong>Complexity</strong>&lt;br&gt;The intricate entanglement of 2 or more systems</td>
<td>Patient in acute renal failure requiring continuous renal replacement therapy</td>
<td>Patient with end-stage renal disease who requires hemodialysis every 3 days</td>
</tr>
<tr>
<td><strong>Predictability</strong>&lt;br&gt;A characteristic that allows one to expect a certain course of events or illness</td>
<td>Patient after emergent cardiac surgery who is in cardiogenic shock</td>
<td>Patient 24 hours after uncomplicated coronary artery bypass graft, no variances on the clinical pathway</td>
</tr>
<tr>
<td><strong>Vulnerability</strong>&lt;br&gt;Susceptibility to actual or potential stressors that may adversely affect outcome</td>
<td>Patient in acute alcohol withdrawal, exhibiting signs of delirium</td>
<td>Patient with history of alcohol use who is alert and oriented several days after admission</td>
</tr>
<tr>
<td><strong>Resiliency</strong>&lt;br&gt;The capacity to return to a restorative level of functioning by using compensatory mechanisms; the ability to bounce back quickly from injury</td>
<td>Elderly trauma patient with history of chronic obstructive pulmonary disease and pulmonary contusion</td>
<td>Young trauma patient with pulmonary contusion</td>
</tr>
</tbody>
</table>
the “minimum standard.” Frequency of assessment and frequency of documentation should be driven primarily by what is going on with the patient rather than by a rigid documentation schedule.

In summary, it would be easy to set standards for assessment and documentation if they were specifically defined by the regulatory bodies. But the reality is that no national standard can be set because of the variability of patients, nurses, institutions, and available resources. Assessment and subsequent documentation should be determined for each population of patients on the basis of their individual needs in each individual setting. Although that ambiguity can be confusing, it also allows nurses to use their judgment to prioritize and adapt the patient’s care to address the patient’s unique situation. This is a great example of the Synergy Model at work. CCN

Financial Disclosures
None reported.

References

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Standards for Frequency of Measurement and Documentation of Vital Signs and Physical Assessments
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