Hints & Tips for the Recording of Adult Physiological Observations

**BLOOD PRESSURE**

When taking your patients blood pressure, please ensure that you have a range of blood pressure cuffs available as ‘miscuffing’ can introduce large errors in measurement. Undercuffing (using either a too narrow or too short a bladder) can give falsely high readings. ‘Overcuffing’ (using either a too wide or too long a bladder) can give falsely low readings.

**FREQUENCY OF OBSERVATIONS**

All patients admitted via the Emergency Departments and Clinical Decision Units must have their observations taken (as a minimum) 4 hourly for at least the first 24 hours.

**BLOOD GLUCOSE MONITORING**

All Diabetic patients MUST have their blood glucose monitored 4 hourly for at least the first 48 hours.

**FREQUENCY OF OBSERVATIONS**

Patients who have been discharged from a higher level of care, i.e., ITU/HDU must have their observations recorded a minimum of 4 hourly for at least the first 48 hours on the ward.

**BLOOD GLUCOSE MONITORING**

All non diabetic patients MUST have a blood glucose recorded when they are first admitted.

**FREQUENCY OF OBSERVATIONS**

All patients admitted via the Emergency Departments and Clinical Decision Units must have their observations taken (as a minimum) 4 hourly for at least the first 24 hours.

**NEWS**

**NEWS**

NEWS is a simple physiological scoring system that can easily be scored at the patient’s bedside. **It does not** replace your clinical experience and professional judgement.

**FREQUENCY OF OBSERVATIONS**

All non diabetic patients MUST have a blood glucose recorded when they are first admitted.

**BLOOD GLUCOSE MONITORING**

The patients pulse must be taken manually for a full minute prior to taking the blood pressure, this is to identify whether the pulse is weak, irregular or slow. If the patients pulse is any of these, then a manual blood pressure device must be used.

**NEWS**

Any new NEWS score of 3 or more indicates a potential **THREAT** and a RN must consider contacting medical staff to undertake a review of the patient’s current condition. You must then document on the RN checklist/Risk assessment any additional monitoring that maybe required. This includes;

- Sepsis screening
- Blood Sugar Monitoring
- Reviewing or starting a fluid balance chart
- Increased frequency of observations

**BLOOD PRESSURE**

**If you need to recheck the blood pressure, wait 1–2 min before proceeding**

**BLOOD PRESSURE**

When taking the blood pressure rap the cuff of the sphygmomanometer around the arm, with the bladder centred over the artery and superior to the elbow. The lower edge of the cuff should be 2–3 cm above the brachial artery pulsation.

**PAIN ASSESSMENT**

For patients who are unable to verbalise their pain you must use the Abbey Pain Tool in order to observe their behaviour.

**SEPSIS**

When it is confirmed by a doctor that the patient has sepsis please ensure that there are entries in all of the sepsis six boxes

**PATIENT REFUSES TO HAVE THEIR OBSERVATIONS TAKEN**

If your patient refuses to have their observations taken. This must be documented as “declined” on the NEWS chart.

The circumstances must be documented within the nursing documentation.

You must try and re-take the observations at the earliest opportunity.

**FLUID BALANCE CHARTS**

When patients are having their fluid balance monitored it is essential that this is undertaken on an hourly basis.

**TAKING THE PULSE**

**When taking the pulse**

The patient’s pulse must be taken manually for a full minute prior to taking the blood pressure, this is to identify whether the pulse is weak, irregular or slow. If the patient’s pulse is any of these, then a manual blood pressure device must be used.

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Please refer to the **“Monitoring and Recording of Adult Observations and the Response to Physical Deterioration Policy”** for full details.