**VITAL SIGNS and CHARTING**

**HEIGHT AND WEIGHT**
- Height and weight are recorded on first visit.
- On subsequent visits, patient is weighed but initial height measurement is automatically carried forward in PnC. Recheck height if patient states previous height is inaccurate.
- Extraneous clothing and shoes with heels should be removed.
- All patients can stand backwards on the scale. If they ask about their weight, offer something like “we can review all your vital signs in a private exam room”.

**BP, TEMP, PULSE, RESPIRATIONS**
- Blood pressure, pulse, respirations, and temperature are all measured and recorded in chart.
- Make note of anything unusual, such as “drinking cold/hot drink” or recent antipyretic meds used.
- Recheck any vital sign that does not make sense and report any outside of normal parameters.
- Report any temperature 101 or greater to Charge Nurse to assess for initiation of antipyretic.

**ORTHOSTATICS**
- Orthostatic vital signs are done to check for dehydration or other instability from vomiting, diarrhea, high fever, heat stroke, malnutrition, severe injury, shock or severe eating disorders.
- Orthostatic vital signs should be obtained prior to clinician evaluation only when requested by nursing staff (Triage or other) or a clinician.
- Obtaining orthostatic should not delay the clinician’s schedule or interfere with emergency care.
- Blood pressure and pulse are taken after patient is fully supine for three minutes, and then repeated after patient standing for three minutes (or sitting if cannot stand without feeling faint).
- The supine numbers should be entered in regular “vital signs” section, with both positions entered in “orthostatic” section.

**PULSE OX AND PEAK FLOWS**
- Pulse ox should be done for all patients with cough, shortness of breath, or respiratory complaints, regardless of duration of symptoms.
- Peak flows:
  - Obtain from all patients presenting with respiratory complaints and a history of asthma
  - Obtain from all patients requesting refills of asthma medications
  - Done three times with patient in a standing position
  - Peak flows with poor effort do not provide reliable data. Patients must be coached in proper technique. Document poor effort in EMR when appropriate.

**PATIENTS WITH EATING DISORDERS**
Take height only 1 time and use this height for all future visits for accurate BMI tracking
- Nurse/MA rooming the patient opens: Initial ED visit = “UCSC Eating Disorder Initial Visit” template. For follow-up open the “UCSC Eating Disorder Follow-up” template.
- MA/Nurse rooming the patient checks Problem List and Appointment Comments for special rooming instructions, i.e. “weigh in gown”, etc.
- Unless noted otherwise, at every visit all ED patients should:
  - Be weighed with back to scale, note clothing worn, defer any weight questions to clinician
  - Have orthostatic vital signs taken—fully supine after 3 min, standing after 3 min
- Orthostatic vitals are recorded in the “Orthostatic Vitals” section with the supine BP & P in the regular VS area of the encounter and both patient positions recorded in the Orthostatic section.
VITAL SIGNS and CHARTING, con’t

DOCUMENTING ALLERGIES & MEDICATIONS
Confirm current medications and allergies at every visit
- Allergies: document presence/absence of medication, material, and environmental allergies
- Medications:
  - Search the medication database whenever possible; avoid free-texting medications into the chart
  - Drug Alert process:
    - Print Alert, acknowledge Alert in PnC,
    - Document in chart note with your initials, “Drug alert printed and given to clinician”
    - Attach printed Alert to out guide and give to clinician