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| <b>SECTION 8A: CLINICAL PRACTICES</b>                | <b>POLICY: 8A.0</b>  |
| <b>POLICY: ASSESSMENT PROTOCOLS &amp; DEVIATIONS</b> | <b>PAGE: 1 OF: 5</b> |

**PURPOSE:**

- Establish protocols for nurses to follow when taking vital signs and conducting body system assessments during home visits, ensuring consistent care across all patients.
- Provide clear guidelines to help nurses accurately measure and record vital signs, reducing the likelihood of errors in patient health monitoring.
- Enable identification of potential health issues through regular and consistent assessments, allowing for timely interventions.
- Allow for necessary deviations based on individual patient conditions, empowering nurses to use clinical judgment in tailoring care.
- Ensure timely reporting of abnormal findings to appropriate parties, facilitating prompt interventions and continuity of care.

**POLICY: REPORTING**

- When abnormal findings are assessed, the nurse shall report the findings to a Clinical Supervisor, Director or Care Manager as immediately as feasible so that the provider and the authorizing Pharmacy (as applicable) can be notified.
- Abnormal findings and reporting of such shall be documented in the nursing note.
- Examples of abnormal findings may include, but are not limited to:
  - Vital signs significantly outside normal range that affect and/or may be affected by the ordered therapy, care, and/or services to be provided
  - Issues with patient tolerance during or after infusion/medication administration
  - Complications with established intravenous access or the inability to obtain access
  - Insufficient supplies to complete ordered therapy
  - Any patient/environmental concern(s) that might prohibit infusion

|                                           |               |
|-------------------------------------------|---------------|
| SECTION 8A: CLINICAL PRACTICES            | POLICY: 8A.0  |
| POLICY: ASSESSMENT PROTOCOLS & DEVIATIONS | PAGE: 2 OF: 5 |

## **POLICY: ASSESSMENTS/MEASUREMENTS**

- **Blood Pressure:** via Sphygmomanometer (manual or digital) and stethoscope (if using a manual cuff).

Ensure the patient is seated, with feet flat on the floor and arm at heart level.

Wait at least 5 minutes after the patient has been seated before taking the reading.

Recheck if the reading seems abnormal.

- Manual: Place the cuff on the patient's upper arm, ensuring it's snug but not too tight. Place the stethoscope over the brachial artery (inside of the elbow). Inflate the cuff to about 20-30 mmHg above the patient's normal systolic pressure. Slowly deflate the cuff, listening for the first (systolic) and last (diastolic) sounds. Record the readings as systolic/diastolic (e.g., 120/80 mmHg).
- Digital: Place the cuff on the upper arm or wrist (as applicable) and start the machine. Wait for the reading and document the results.

Normal Range for Adults: 120/80 mmHg

Normal Range for Pediatrics:

| <u>Age</u>  | <u>Normal BP (approx. mm/Hg)</u> |
|-------------|----------------------------------|
| 1-3 years   | ~ 95-110 / 60-75                 |
| 4-6 years   | ~ 95-110 / 60-75                 |
| 7-10 years  | ~ 100-115 / 60-75                |
| 11-13 years | ~ 110-125 / 65-80                |
| 14-17 years | ~ 115-130 / 70-85                |

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|-------------------------------------------|---------------|
| SECTION 8A: CLINICAL PRACTICES            | POLICY: 8A.0  |
| POLICY: ASSESSMENT PROTOCOLS & DEVIATIONS | PAGE: 3 OF: 5 |

- **Respirations:** via observation.
  - Without alerting the patient (to prevent altered breathing), observe the rise and fall of the chest. Count the number of breaths for 30 seconds and multiply by 2 for breaths per minute.
- **Pulse:** Using a watch or digital timer (and stethoscope if needed).  
Document any irregularities or weak pulses.
  - Radial Pulse: Locate the radial artery on the wrist, just below the thumb. Use the pads of your index and middle fingers to feel the pulse. Count the beats for 30 seconds and multiply by 2 for beats per minute (BPM).
  - Apical Pulse (if needed): Use a stethoscope to listen to the heart at the apex (left chest, just below the nipple). Count the beats for one full minute.

Normal Range for Adults: 60-100 BPM

Normal Range for Pediatrics:

| <u>Age Group</u>         | <u>Normal Pulse Rate (beats per minute)</u> |
|--------------------------|---------------------------------------------|
| Newborn (0–1 month)      | 100–180 bpm                                 |
| Infant (1–12 months)     | 100–160 bpm                                 |
| Toddler (1–3 years)      | 90–150 bpm                                  |
| Preschool (3–5 years)    | 80–140 bpm                                  |
| School-age (6–12 years)  | 70–120 bpm                                  |
| Adolescent (13–18 years) | 60–100 bpm                                  |

|                                           |               |
|-------------------------------------------|---------------|
| SECTION 8A: CLINICAL PRACTICES            | POLICY: 8A.0  |
| POLICY: ASSESSMENT PROTOCOLS & DEVIATIONS | PAGE: 4 OF: 5 |

- **Temperature:** Using a Digital Thermometer; sanitize before and after each use. The nurse may obtain temperature by any of the following methods:
  - Oral: Ensure patient has not had any hot or cold beverages within 15 minutes. Place the thermometer under the tongue, ensuring it's in contact with the sublingual pocket. Wait until the thermometer beeps and note the reading.
  - Axillary: Place the thermometer in the armpit, ensuring skin contact. Wait until it beeps, then record the temperature.
  - Tympanic: Gently insert the thermometer in the ear canal, ensuring a snug fit. Wait for the beep, then record the reading.

| Measurement Site           | Normal Range (°C) | Normal Range (°F) |
|----------------------------|-------------------|-------------------|
| Oral                       | 36.4–37.6°C       | 97.5–99.7°F       |
| Axillary (armpit)          | 35.9–37.2°C       | 96.6–99.0°F       |
| Tympanic (ear)             | 36.4–38.0°C       | 97.5–100.4°F      |
| Forehead (temporal artery) | 36.1–37.4°C       | 97.0–99.3°F       |

- **Height:** document as reported verbally by the patient or caregiver
- **Weight:** document as reported verbally by the patient or caregiver
- **Sex:** document as reported verbally by the patient or caregiver
- **Pain:** document as reported verbally by the patient or caregiver utilizing a scale of 1 – 10 for intensity, location, and any other descriptors provided.

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|------------------------------------------------------|----------------------|
| <b>SECTION 8A: CLINICAL PRACTICES</b>                | <b>POLICY: 8A.0</b>  |
| <b>POLICY: ASSESSMENT PROTOCOLS &amp; DEVIATIONS</b> | <b>PAGE: 5 OF: 5</b> |

### **POLICY: BODY SYSTEMS**

- During each Admission / Start of Care (SOC) visit, the nurse will conduct a comprehensive head-to-toe assessment, to include the following systems, and document any abnormalities:
  - Musculoskeletal
  - Neurological / Mental Status
  - Respiratory
  - Gastrointestinal
  - Cardiovascular
  - Endocrine
  - Genitourinary / Urinary
  - Integumentary / Skin
  - Sensory / Eyes / Hearing
  - Psychosocial
  
- Additionally, the SOC visit will include a home safety assessment, admission education, and other SOC-specific elements to further identify any barriers to care delivery that may be reportable.
  
- Subsequent visits focus on teaching, drug administration, and/or delivery of ordered therapy; however, the nurse shall continue to monitor and assess the patient's overall health and shall continue to assess the primary body systems and take at least one set of vitals at each visit to ensure there are no abnormalities, changes, or contraindications to care delivery.
  - The nurse will obtain at least one full set of vital signs during each visit. Some visits may require more frequent monitoring of vital signs based on the patient's condition and care needs.