# Taking Vital Signs: A Mundane Responsibility?

written by Nancy Brent | November 2, 2016

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It does not matter in which role you practice nursing—R.N., APRN, nursing student or a C.N.A.—vital signs are something that you all do. You may sometimes think taking them is so routine you do so without much enthusiasm and sometimes without really paying attention to the results. A recent study by The Canadian Medical Protective Association underscores the importance of vital signs and what results can occur when health care providers do not heed vital signs' warnings.

The study, conducted from 2006-2012, reviewed 55 closed medical-legal cases that mainly involved physicians, but where nursing staff were also included in some way. The common themes identified were "a failure to obtain, record, acknowledge, interpret, repeat, or act upon vital signs". [1]

One of the cases in the study involved a 10-month-old infant who was brought to the ED. His weighed 22 pounds. His presenting symptoms were fever, vomiting, diarrhea, and irritability for the past 2 days. ED staff observed that the infant was also mottled. His vital signs were: P=180, T=101, R=40, and oxygen saturation, 98%.[2]

A pediatric resident assessed the infant and blood work and a bolus of normal saline was ordered and initiated. A lumbar puncture was also done which was clear. Antibiotics and additional fluid were administered.

The pediatric resident and a pediatric resident assigned to the general pediatric ward agreed that the infant be admitted for observation and continued hydration. No additional vital signs were taken after admission in the ED.

Five hours after presenting in the ED, the admitting nurse on the pediatric ward observed that the infant was mottled and his vital signs were: P=180, T=102.2, R=70. The nurse immediately notified the resident but the infant arrested and was unable to be resuscitated. His autopsy showed peritonitis due to a ruptured appendix.[3]

A suit was filed and the trial verdict was against both the ED physicians and nurses due to their negligence in the monitoring and the treatment of the infant.

This death clearly could have been avoided. Not only did the physician and nursing staff fail to take continuous vital signs and therefore monitor the infant's progress or lack of it, there was no attempt to differentially diagnose why the infant presented with the vital signs that he did.

The case supports many guidelines that should be followed when any patient, but certainly an infant,

presents with abnormal vital signs.  Some of those guidelines include:

1. Be certain to use the correct techniques when taking vital signs;
2. Take vital signs when you see a patient, whether for the first time or thereafter;
3. Always ask the patient or a family member what their “normal” vital signs are;
4. If an individual’s vital signs are abnormal, document them, immediately contact whomever you need to contact, and continue to take vital signs until they are normal;
5. Never assume that abnormal vital signs indicate one condition over all others;
6. Obtain as much information as you can from the patient or a family member about how the patient was feeling prior to seeing you, any additional symptoms, and other relevant signs;
7. When taking vital signs, focus your full attention on the patient and the vital signs results;
8. Never falsify a patient’s vital signs;
9. Always document vital signs obtained, including the time and date; and
10. When in doubt about a patient’s status as a result of his or her vital signs, immediately share your concerns with your nurse manager, the patient’s physician, faculty member, or another APRN in order to further evaluate the patient and allow needed treatment to begin, if needed.

**FOOTNOTES**

1. The Canadian Medical Protective Association (2014), “Can I Take Your Vital Signs?” Key Learnings from 3 Case Studies.  Available at: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/can-i-take-your-vital-signs-key-learnings-from-3-case-studies.
2. Id.
3. Id.

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