



EHR Go Guide: Vitals, Pain, and Measurement

Introduction

Vital signs are an important aspect of patient care and diagnosis. They often provide the first indication of a change in the patient's health status and can also provide a historical trend to help identify longer term changes in the patient's condition. Vital signs are also used to provide a baseline to determine the effectiveness of a treatment plan. Accurate vital measurements and entry are essential components of safe practice.

The Vitals tab in EHR Go includes documentation for all types of vitals measurements including: temperature, pulse, respiration, blood pressure, and pulse oximetry (TPR B/P O2), as well as Pain, Intake & Output, Growth, Capillary Glucose, and a Quick Survey of the patient to identify abnormal findings that may need further assessment. This guide explains how to access and review existing vitals entries, edit vitals entries, and create new vital and measurement entries.

Additional resources

Please refer to the *Student Guide to EHR Go* for information on logging in to Go and launching the EHR for an activity.

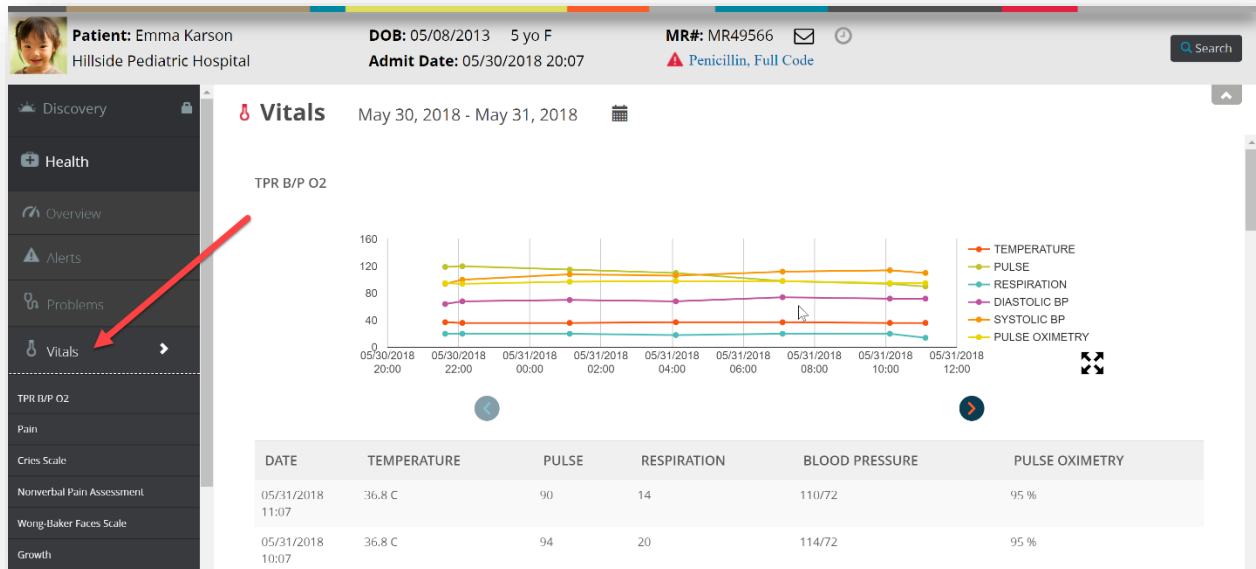
FAQs about vitals entries

1. **Can I edit a vitals entry after I have finished it?**
 - a. Yes. All vital entries may be edited. Select the entry from the list view, then select Edit.
2. **How do I submit my vitals entries to my instructor?**
 - a. Your completed work is submitted to your instructor through the Progress Report found under Step 3: Download Work. See *Go! Guide to Completing and Submitting Work*.
3. **Will other users see vitals entries that I have written?**
 - a. No. All users see their own instance of the chart. Your work is private.

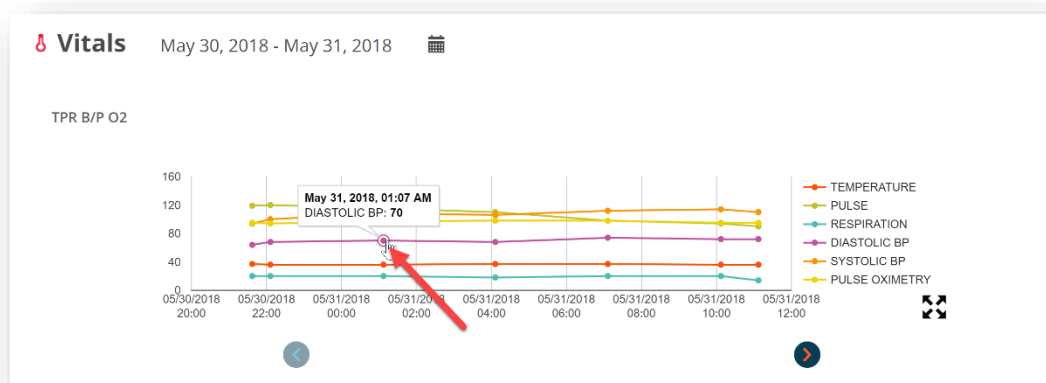
Accessing vitals entries in the EHR



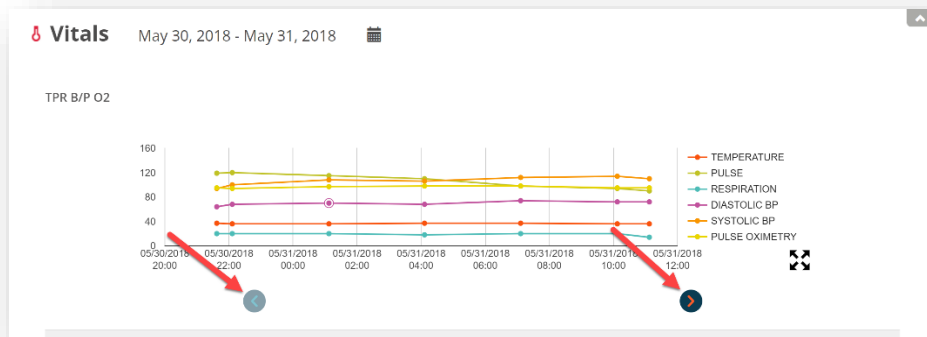
After launching the EHR for any patient chart, select the Vitals tab on the left side of the screen



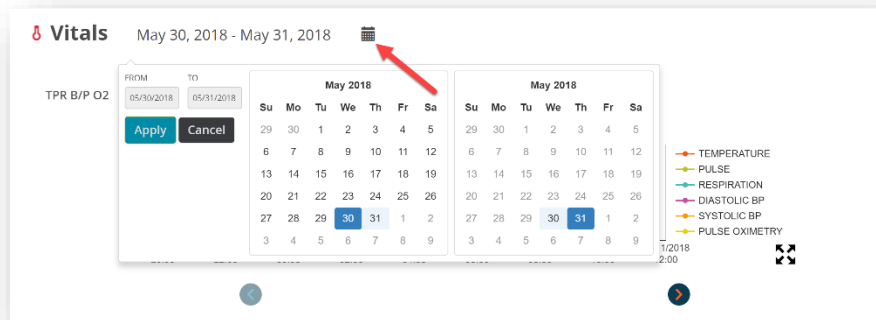
The Temperature, Pulse, Respiration, Blood Pressure, and Pulse Oximetry (TPR B/P O2) entries are displayed first with a trend graph. Hover over a data point with your mouse to view the value and timestamp.



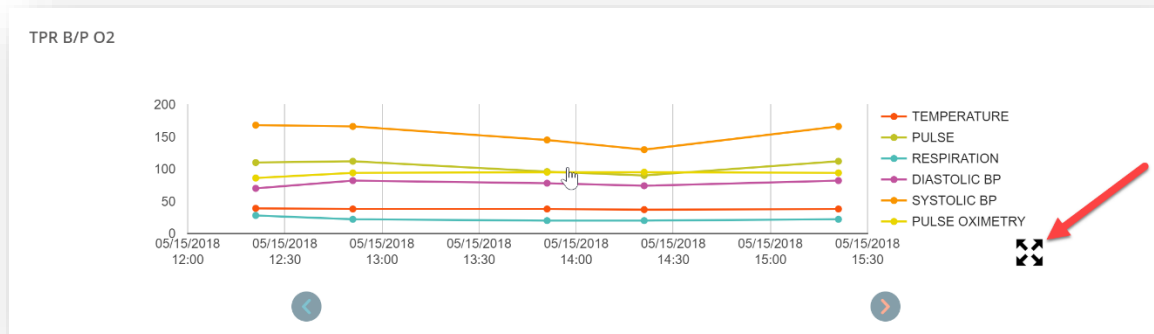
Depending on the number of entries and the time course, you may need to use the arrows to scroll through additional data points.

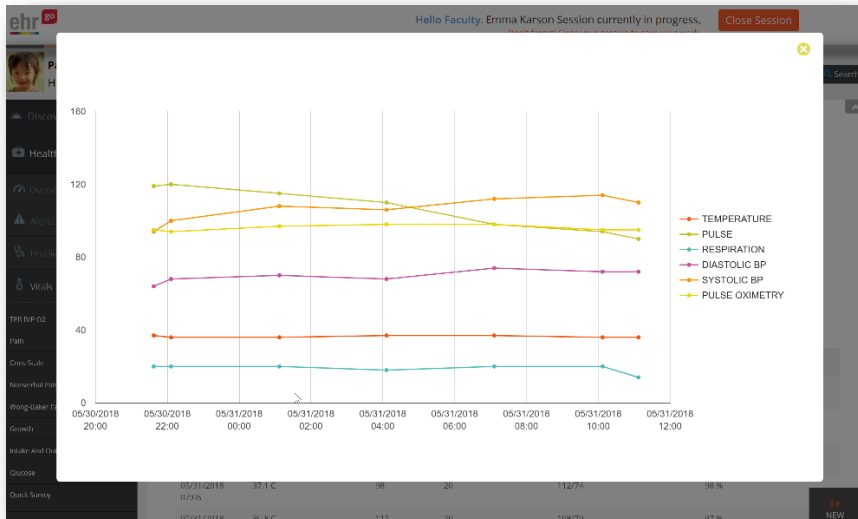


The time display (x-axis) may be adjusted by selecting the calendar icon above the graph:



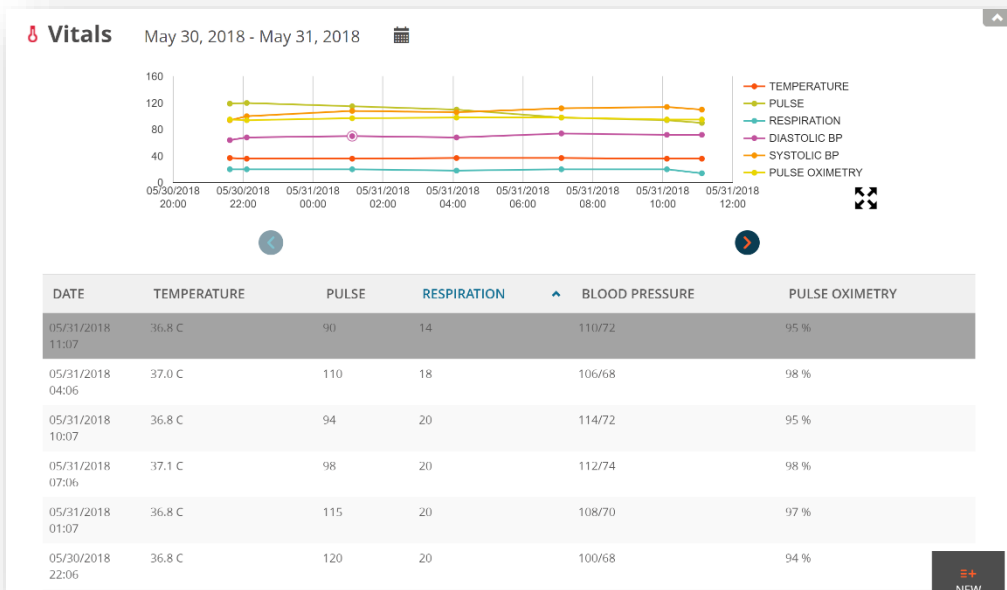
To see a full graph with all data points, click the four arrows icon for a pop-out display.





The pop-out graph can be closed by clicking the X in the upper right corner.

Scroll down to see the numeric table view of the vitals entries.





Click on any individual entry in the table to display the Vital Details. The Vital Details includes any qualifiers and descriptions related to the measurements as well as any other vital entries that occurred at that time.

ehr go Hello Faculty, Emma Karson Session currently in progress. Close Session Don't forget Close your session to save your work.

Patient: Emma Karson Hillside Pediatric Hospital DOB: 05/08/2013 5 yo F MR#: MR49566 Penicillin, Full Code

Search

Vital Details

Entry date: 05/31/2018 11:07

Vitals	Value	Unit	Qualifier(s)	Description
Temperature :	36.8	C	Oral	
Pulse :	90			
Respiration :	14			
Blood Pressure :	110/72			
Pulse Oximetry :	95	%		

Wong-Baker Faces Scale

Vitals	Value
Pain :	0 - NO HURT

EDIT CLOSE NEXT

From the Vital Details window, you may select the following options:

Previous: Scrolls to the previous vital entry if you're not at the first listing.

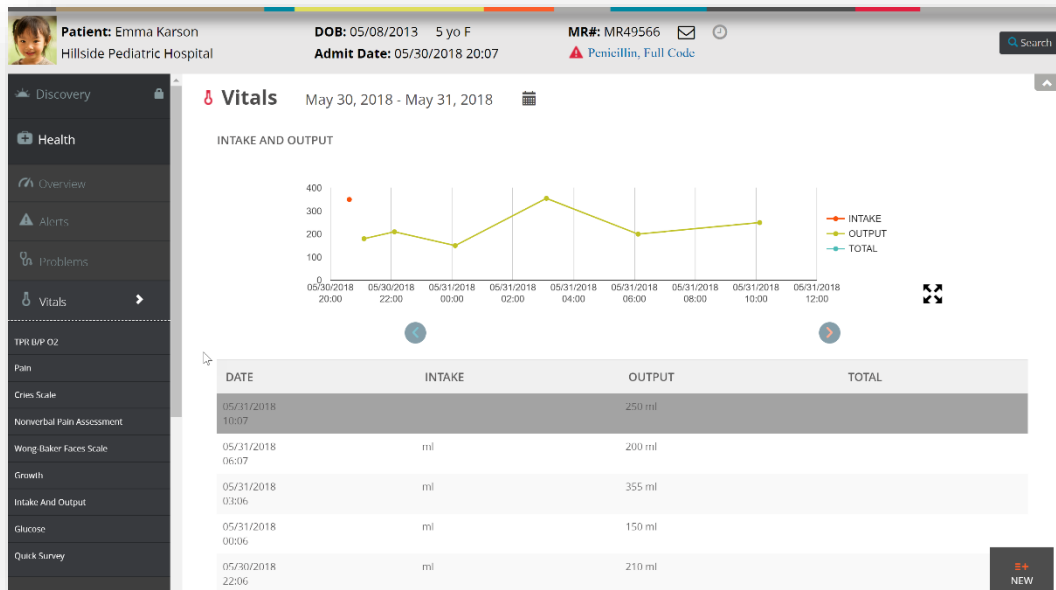
Delete: If you entered the vital set, you may delete it. This option will not be available for vital sets that were not entered by you.

Edit: Allows you to change the values associated with the entry (see next section).

Close: Closes out of the Vital Details window and returns to the Summary view.

Next: Scrolls to the next vital entry if you're not at the last listing.

Depending on the patient, there may be a variety of vitals entries on the vitals tab. Back on the summary view, scroll down to view Pain, Cries Scale, Nonverbal Pain Assessment, Wong-Baker Faces Scale, Growth, Intake and Output, Glucose, and Quick Survey entries, if applicable.



Like the TPR B/P O2 section, many of the other sections will begin with a graphical view followed by a table listing of the entries. If a section is not displayed, it is because no historic entries for that specific measurement were documented.

Editing existing vital entries

Any existing entry on the Vitals tab may be edited regardless if you made the original entry or if it was historic data included with the patient.

Scroll through the Vitals tab and select the list entry for the measurement you'd like to change.



Patient: Emma Karson
Hillside Pediatric Hospital

DOB: 05/08/2013 5 yo F
Admit Date: 05/30/2018 20:07

MR#: MR49566
▲ Penicillin, Full Code

Vitals May 30, 2018 - May 31, 2018

Date/Time	Value
05/31/2018 07:06	0 - NO HURT
05/31/2018 04:07	0 - NO HURT
05/31/2018 04:06	0 - NO HURT
05/31/2018 03:06	0 - NO HURT
05/31/2018 00:06	2 - HURTS A LITTLE
05/30/2018 22:06	4 - HURTS A LITTLE MORE
05/30/2018 21:06	4 - HURTS A LITTLE MORE
05/30/2018 20:07	4 - HURTS A LITTLE MORE

From the Vitals Details screen, select **Edit**.

Patient: Emma Karson
Hillside Pediatric Hospital

DOB: 05/08/2013 5 yo F
Admit Date: 05/30/2018 20:07

MR#: MR49566
▲ Penicillin, Full Code

Vital Details

Entry date: 05/30/2018 20:07

TPR R/P O2

Vitals	Value	Unit	Qualifier(s)	Description
Temperature:	37.0	C	Oral	
Pulse:	130			
Respiration:	32			
Blood Pressure:	80/52			
Pulse Oximetry:	93	%		

Wong-Baker Faces Scale

Vitals	Value
Pain:	4 - HURTS A LITTLE MORE

PREVIOUS EDIT CLOSE



All entries associated with that vital entry time will be displayed. Scroll to the entry you'd like to change and update it. Then select **Save**.

Note: if you'd like to include additional measurement values associated with the existing entry time, you may enter those values as well.

Patient: Emma Karson
DOB: 05/08/2013 5 yo F
MR#: MR49566
Admit Date: 05/30/2018 20:07
Penicillin, Full Code

Vital Edit

Vitals	Value	Describe
Guarding:	<input type="text"/>	<input type="text"/>
Physiology:	<input type="text"/>	<input type="text"/>
Respiratory:	<input type="text"/>	<input type="text"/>

Wong-Baker Faces Scale

Vitals	Value
Pain:	<div><div>0</div><div>2</div><div>4</div><div>6</div><div>8</div><div>10</div></div> <div><div>NO HURT</div><div>HURTS A LITTLE</div><div>HURTS A LITTLE MORE</div><div>HURTS EVEN MORE</div><div>HURTS WHOLE LOT</div><div>HURTS WORST</div></div>

Growth

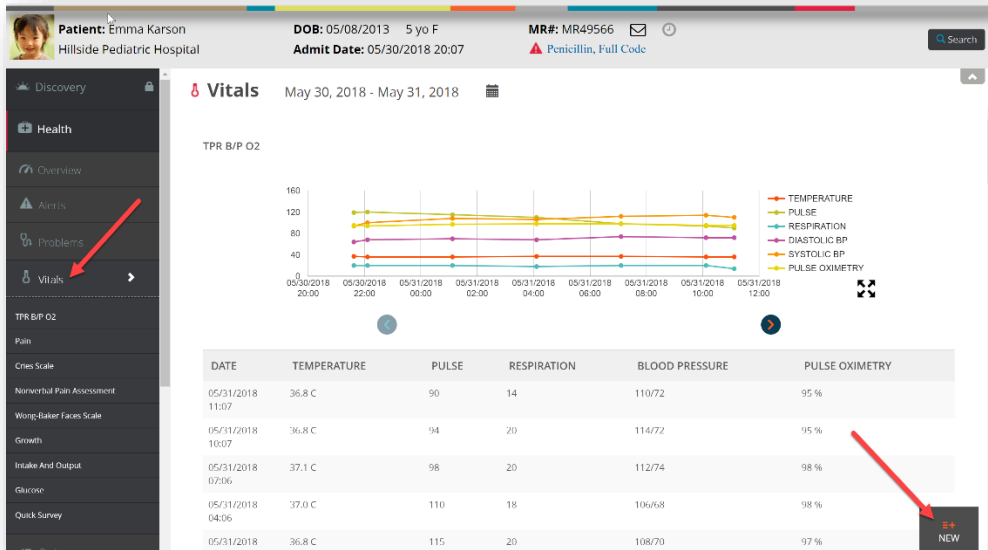
Vitals	Value	Unit	Qualifier(s)	Description
Weight:	17.2	kg	Growth Chart	<input type="text"/>
Height/Length:	44.5	in	Growth Chart	<input type="text"/>

SAVE **CANCEL**

The updated vital entry will be included in the Progress Report that you'll submit to your instructor.

Entering new vital signs measurements

After selecting the Vitals tab in any patient chart, select **New** in the bottom-right corner to author a new entry in the chart.



The Vital Edit screen will appear. By default, the current date and time will populate the Entry date field. Select the calendar icon to change the date and time, if desired.

Patient: Emma Karson
Hillside Pediatric Hospital
DOB: 05/08/2013 5 yo F
Admit Date: 05/30/2018 20:07
MR#: MR49566
Penicillin, Full Code

Vital Edit

Entry date: 05/31/2018 14:11

TPR B/P O2

Vitals	Value	Unit	Qualifier(s)	Description
Temperature:		Unit	Location	Describe
Pulse:			Location Method Position	Describe
Respiration:			Method	Describe
Blood Pressure:			Location Method Position	Describe
Pulse Oximetry:		%	Flow rate (l/min) O2 % Method	Describe

Pain

Vitals	Value	Description
Pain:	Value	Describe

SAVE **CANCEL**



Fill in the values for any vital measurements associated with this entry. Scroll down to view the additional measurement sections. You may choose to complete as many sections as appropriate for the patient. Sections that aren't populated will be suppressed from the vitals set of results. When you're finished with all applicable entries, select **Save**.

TPR BP O2

For each vital that was measured, enter the numeric value. For temperature, select a unit (Celsius (C) or Fahrenheit (F)). For blood pressure, enter the systolic reading/diastolic reading (ex. 120/80).

- Temperature
- Pulse
- Respiration
- Blood Pressure
- Pulse Oximetry

Depending on the measurement, one or more Qualifiers may be selected as appropriate. Enter any additional information in the Description field.

If the Patient is on Oxygen at the time of the measurement, fill in the following:

- Flow rate in L/min
- Percentage of O2 being administered
- Delivery method for the O2

If the Patient is not on Oxygen at the time of the measurement, enter "Room Air" in the Flow rate field.

Pain

Four pain scales are available to choose from. Select the best pain scale for the patient.

Numeric Scale:

A simple scale for assessing pain.



- Select a value from 0 to 10, where 0 is no pain, and 10 is the worst pain imaginable. If the patient is unable to respond, select “99”.
- Enter comments in the Description field, as applicable.

CRIES Scale:

This scale is used to evaluate pain in neonatal patients. Evaluation of five criteria leads is used to determine a total pain score.

Select a value of 0, 1, or 2 for each criterion based on the descriptions in the drop-down menu. An optional description may be included with each measurement.

- Crying
- Requires O2 for SaO2<95%
- Increased Vital Signs (BP & HR)
- Expression
- Sleepless

For reference, a table view of the CRIES scale is shown below. Results may be summed for a total ranging from 0 to 10.

DATE/TIME						
Crying - Characteristic cry of pain is high pitched. 0 - No cry or cry that is not high-pitched 1 - Cry high pitched but baby is easily consolable 2 - Cry high pitched but baby is inconsolable						
Requires O₂ for SaO₂ < 95% - Babies experiencing pain manifest decreased oxygenation. Consider other causes of hypoxemia, e.g., oversedation, atelectasis, pneumothorax) 0 - No oxygen required 1 - < 30% oxygen required 2 - > 30% oxygen required						
Increased vital signs (BP* and HR*) - Take BP last as this may awaken child making other assessments difficult 0 - Both HR and BP unchanged or less than baseline 1 - HR or BP increased but increase in < 20% of baseline 2 - HR or BP is increased > 20% over baseline.						
Expression - The facial expression most often associated with pain is a grimace. A grimace may be characterized by brow lowering, eyes squeezed shut, deepening naso-labial furrow, or open lips and mouth. 0 - No grimace present 1 - Grimace alone is present 2 - Grimace and non-cry vocalization grunt is present						
Sleepless - Scored based upon the infant's state during the hour preceding this recorded score. 0 - Child has been continuously asleep 1 - Child has awakened at frequent intervals 2 - Child has been awake constantly						
TOTAL SCORE						



Nonverbal Pain Assessment:

This scale is used to assess patients who cannot speak or otherwise indicate their pain value. A total score is derived from five different criteria.

Select a value of 0, 1, or 2 for each criterion based on the descriptions in the drop-down menu. An optional description may be included with each measurement.

- Face
- Activity
- Guarding
- Physiology
- Respiratory

For reference, a table view of the Nonverbal Pain Scale is shown below. Results are summed for a total ranging from 0 to 10.

	0	1	2	Score
1. Face	No particular expression or smile	Occasional grimace, tearing, frown or wrinkled forehead	Frequent grimace, tearing, frown or wrinkled forehead	
2. Activity (movement)	Lying quietly, normal position	Seeking attention through movement of slow cautious movements.	Restless activity and/or withdrawal reflexes	
3. Guarding	Lying quietly, no positioning of hands over areas of body	Splinting areas of the body, tense	Rigid, stiff	
4. Physiologic I (vital signs)	Stable vital signs, no change in past 4 hours	Change over past 4 hours in any of the following: SBP >20 HR >20 RR >10	Change over past 4 hours in any of the following: SBP >30 HR >25 RR >20	
5. Respiratory	Baseline RR/Spo ₂ Complaint with ventilator	RR >10 above baseline or 5% ↓ Spo ₂ Mild asynchrony with ventilator	RR >20 above baseline or 10% ↓ Spo ₂ Severe asynchrony with ventilator	
Revised Nonverbal Pain Scale (NVPS)				Total

Wong-Baker Faces Scale:

Using this method, a pain scale is assigned based on standard facial expressions.



Wong-Baker Faces Scale					
Vitals	Value				
Pain:					
	0	2	4	6	8
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	NO HURT	HURTS A LITTLE	HURTS A LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT
					10
					<input type="radio"/>
					HURTS WORST

Growth

This section is used to document Weight, Height/Length, Head Circumference, and Body Mass Index (BMI). Enter the numeric value and unit of measure for each vital. If applicable, select a Growth Chart Qualifier and/or enter a Description.

BMI is calculated by dividing weight (in kg) by height (in meters) and there are no units.

Growth				
Vitals	Value	Unit	Qualifier(s)	Description
Weight:	<input type="text" value="120"/>	<input type="text" value="lb"/> ▾	<input type="text" value="Growth Chart"/> ▾	<input type="text" value="Describe"/>
Height/ Length:	<input type="text" value="66"/>	<input type="text" value="in"/> ▾	<input type="text" value="Growth Chart"/> ▾	<input type="text" value="Describe"/>
Head Circumference:	<input type="text"/>	<input type="text" value="Unit"/> ▾	<input type="text" value="Growth Chart"/> ▾	<input type="text" value="Describe"/>
BMI:	<input type="text"/>			<input type="text" value="Describe"/>

Intake & Output

This section is used to track fluid balance.

Intake: Document how much fluid was gained (in ml) and the method in which the patient gained the fluids. If more than one method was used, select “Other”.



Output: Document how much fluid was lost (in ml) and the method in which the fluids were lost. If more than one method occurred, select “Other”.

Total: Compute and enter the total. Indicate whether the patient had a fluid gain, loss, or none in the Fluid Shift dropdown. In the Total Time field, select the length of time represented by the current entry. Add comments in the Describe space as needed.

Intake & Output					
Vitals	Value	Unit	Qualifier(s)		Description
Intake:	<input type="text"/>	ml	Method <input type="text"/>	% of Meal Consumed <input type="text"/>	Describe <input type="text"/>
Output:	<input type="text"/>	ml	Method <input type="text"/>		Describe <input type="text"/>
Total:	<input type="text"/>	ml	Fluid Shift <input type="text"/>	Total Time <input type="text"/>	Describe <input type="text"/>

Glucose

Enter the capillary blood glucose reading and corresponding unit of measure. Enter comments in the Description field, if applicable.

Glucose			
Vitals	Value	Unit	Description
Capillary blood glucose reading:	<input type="text"/>	Unit <input type="text"/>	Describe <input type="text"/>

Quick Survey

This tool is a checklist for a head-to-toe assessment. For the items in each section, indicate whether they were Not Assessed, Within Normal Limits (WNL), or Abnormal. Use the corresponding systems assessment notes found on the Notes Tab to document a complete assessment of any systems with abnormal findings.



- Level of Consciousness and Orientation
- HEENT/Neuro
- Skin
- Lungs/Thoracic
- Cardiac/Thoracic
- Abdomen/Coccyx/Genitalia
- Extremities
- Psych/Mental Health
- General

Quick Survey				
Level of Consciousness and Orientation:				
Person:	<input type="radio"/> Not Assessed	<input type="radio"/> WNL	<input type="radio"/> Abnormal	<input type="text" value="Describe"/>
Place:	<input type="radio"/> Not Assessed	<input type="radio"/> WNL	<input type="radio"/> Abnormal	<input type="text" value="Describe"/>
Time:	<input type="radio"/> Not Assessed	<input type="radio"/> WNL	<input type="radio"/> Abnormal	<input type="text" value="Describe"/>
Purpose:	<input type="radio"/> Not Assessed	<input type="radio"/> WNL	<input type="radio"/> Abnormal	<input type="text" value="Describe"/>
HEENT/Neuro:				
Head:	<input type="radio"/> Not Assessed	<input type="radio"/> WNL	<input type="radio"/> Abnormal	<input type="text" value="Describe"/>

After completing the applicable vitals fields and selecting **Save**, the new vitals set will be added to your instance of the patient chart. No other users will see these changes in the patient chart since all users have their own, private instance of the chart.

When you are finished in the patient chart, select **Close Session**. **Important!** This is how your work is saved. Do not close your browser window or tab without clicking Close Session. The Progress Report for this EHR session will be updated with the new or edited orders and you may submit the report to your instructor when you have completed the assignment. If you make edits to the orders in future work on this EHR session, the Progress Report will be updated accordingly.

Vitals on the Overview tab

The Overview tab of the patient chart also includes the most recent vital entry.



Patient: Emma Karson
Hillside Pediatric Hospital

DOB: 05/08/2013 **5 yo F** **MR#:** MR49566 **Penicillin, Full Code**

Admit Date: 05/30/2018 20:07

Overview

Admission	Active	Polyuria	Acute	05/29/2018	Tarun Dasari, DO
Admission	Active	Lethargy	Acute	05/29/2018	Tarun Dasari, DO
Admission	Active	Abdominal pain	Acute	05/28/2018	Tarun Dasari, DO

Vitals [See More >>](#)

TPR B/P O2

DATE	TEMPERATURE	PULSE	RESPIRATION	BLOOD PRESSURE	PULSE OX
05/31/2018 11:07	36.8 C	90	14	110/72	95 %

WONG-BAKER FACES SCALE

DATE	PAIN
05/31/2018 11:07	0 - NO HURT

GLUCOSE

DATE	CAPILLARY BLOOD GLUCOSE READING
05/31/2018 11:07	210 mg/dL

Labs [See More >>](#)

It is not possible to edit vitals or enter new vitals from the Overview tab. You may select **See More** to be brought to the Vitals tab to see the full list of vitals or to edit or add new vitals.