FirstNet
ED Vital Signs

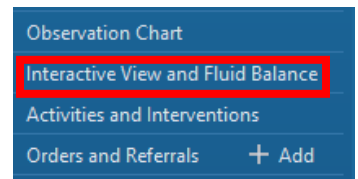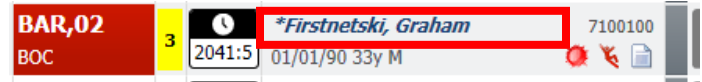**Digital Health**
**Quick Reference Guide**

This Quick Reference Guide will explain how to:

Complete vital sign observations in FirstNet.

Documenting Vital Signs

1. From LaunchPoint open the patient chart by selecting their name.

2. Open 'Interactive View and Fluid Balance' from the menu highlighted in blue on the left hand side of the screen.

3. From this page select the 'ED Vital Signs' heading.
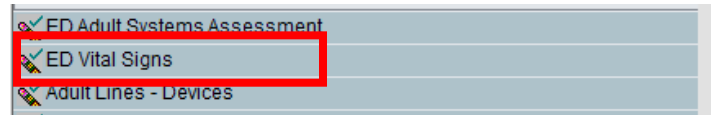
4. The 'VITAL SIGNS' and 'Behaviours of Concern Assessment' document set will automatically populate. You can now import you're Vitals Signs across directly from the Phillips Monitor if device association has been completed (See **QRG 'Device Association and Disassociation'**), or input results manually.
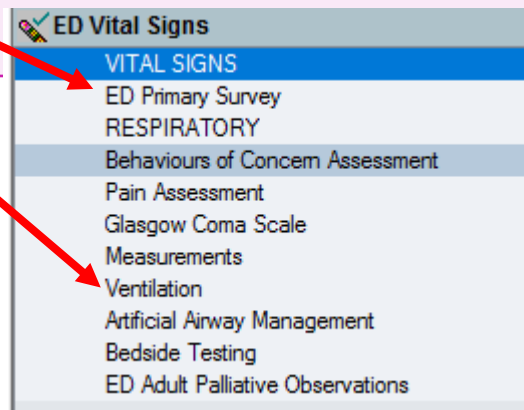
		08/08/2023		
		13:52	13:48	13:30
VITAL SIGNS				
Respiratory Rate	br/min		20	20
Respiratory Distress			Nil	Mild
SpO2	%		96	93
Oxygen Therapy			Yes	
Oxygen Delivery			Nasal prongs	Room air
Probe Location Changed			No	Yes
Oxygen Delivery - High Flow			No	No
Oxygen Flow Rate	L/min			
FiO2	%		21	21
Humidified High Flow Rate	L/min			
SBP/DBP Cuff	mmHg			130/60
Mean Arterial Pressure, Cuff	mmHg			
SBP/DBP Invasive	mmHg			
Peripheral Pulse Rate	bpm			
Heart Rate Monitored	bpm			72
Temperature Temporal	DegC			36.5
Conscious State			Alert	Alert
Looks Unwell			No	No
Family Worry			No	No
New Change in Behaviour/Thinking			No	No
Observation Comments			SATS improved post application of O2. awaiting CXR.	Noted dec Sats. Applied 1L O2 v NP. EDMO notified.

! **Important – Additional Assessments**

The 'VITAL SIGNS' menu only provides clinicians with the option to complete a standard set of vital signs. If your patient requires additional assessments, simply select the relevant assessments from the 'ED Vital Signs' menu. This will allow you to document these additional assessments simultaneously.

Including Airway and Ventilation Observations.

ED Vital Signs

- VITAL SIGNS
- ED Primary Survey
- RESPIRATORY
- Behaviours of Concern Assessment
- Pain Assessment
- Glasgow Coma Scale
- Measurements
- Ventilation
- Artificial Airway Management
- Bedside Testing
- ED Adult Palliative Observations

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5. Check all inputs are accurate and when satisfied select green tick to submit assessment.

💡 Handy Hint – Additional Context When Documenting Vitals

When documenting your patient's vital signs you will be able to see previous assessment outcomes that were documented previously to be able to see how assessment results are trending. You will also be able to see relevant actions or interventions implemented in the 'Observation Comments' section. All of these details are also viewable via the 'ED Nursing Workflow' page to assist with handover, and quickly finding pertinent patient data.

ED Nursing Workflow ✕

Observations

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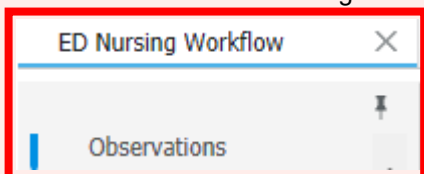
6. Observations will also be viewable on the observation chart. This displays observations in a 'track and trigger' style to easily identify trends.

Observation Chart
Interactive View and Fluid Balance
Activities and Interventions
Allergies/Sensitivities ➕ Add

▼ SpO2 Add
9/8/23 0830   0845   0900
SpO2 (%)