

Understanding Fever: Nursing Assessment and Interventions

Ohoud Sulaiman F Alruwili ¹, Hanadi Jazaa Obeid Almutairi ², Asma Mutarid O Alanazi ³, Intlsar Atiah M Alruwaili ⁴, Gamra Khalaf Suhail Alruwaili ⁵, Fahad Ahmad Mohammed Alsunaydi ⁶, Adhwaa Alohaylim Aldaghmani ⁷, Jamal Alnaqdi S Alruwaili ⁸, Abeer Ayad Ayed Al Faidi ⁹, Abdulkader Salem Saud Alhazimi ¹⁰

- 1- Nursing specialist, Domat Al-Jandal Hospital, Sakaka, Saudi Arabia
- 2- Nursing technician, Mubayyid Health Center, Second Health Cluster, Riyadh, Saudi Arabia
- 3- Nursing technician, Hafar Al-Batin Health Cluster, Hafar Al-Batin, Saudi Arabia
- 4- Nursing technician, North Medical Tower at Arar in Saudi Arabia
- 5- Nursing technician, King Abdulaziz Specialist Hospital, Al-Jouf - Sakaka, Saudi Arabia
- 6- Nursing technician, Prince Moteb bin Abdulaziz Hospital, Sakaka, Al-Jouf, Saudi Arabia
- 7- Nursing technician, Prince Moteb bin Abdulaziz Hospital, Sakaka, Al-Jouf, Saudi Arabia
- 8- Nursing, Ministry of Health Branch- Northern Border Region
- 9- Nursing, Al Sarif Health Center, Yanbu, Saudi Arabia
- 10- Nursing Assistant, Northern Borders Health Cluster, Medical Supply, Arar, Saudi Arabia

Abstract:

Fever is a common physiological response to infection or illness, characterized by an elevation in body temperature above the normal range. In nursing practice, accurate assessment is key to understanding fever's etiology and guiding treatment. Nurses should conduct thorough assessments by obtaining a detailed patient history, noting the onset, duration, and associated symptoms. Objective measurements, such as temperature monitoring using appropriate methods (oral, rectal, or tympanic), are essential. Additionally, vital signs should be closely observed, and any potential underlying factors, like medication use or chronic conditions, must be evaluated. Nursing assessments may also include a review of laboratory results and physical examinations to identify signs of infection or other contributing factors. Interventions for managing fever focus on enhancing patient comfort and addressing the underlying cause. Nursing interventions may include administering antipyretic medications, ensuring adequate hydration, and maintaining a comfortable environment with appropriate clothing and bedding. Educating patients and families about fever management and when to seek further medical care is also crucial. Continuous monitoring of the patient's temperature and overall condition, along with documenting changes, helps to evaluate the effectiveness of interventions. Collaborative care may involve working with other healthcare providers to revise treatment plans as necessary, ensuring a comprehensive approach to patient care.

Keywords: Fever, Nursing assessment, Body temperature, Infection, Vital signs, Antipyretic medication, Patient comfort, Hydration, Education, Collaborative care.

Introduction:

Fever is a common clinical symptom characterized by an elevation in body temperature, typically defined as a temperature exceeding 100.4°F (38°C). It is not a disease itself but rather a physiological response to various underlying conditions, including infections, inflammatory processes, and sometimes malignancies. Fever activates the body's immune response, serving as a defense mechanism against pathogenic entities. Understanding fever's multifaceted nature is essential for healthcare providers, particularly nurses, who play a crucial role in the assessment, monitoring, and management of patients presenting with this symptom [1].

The prevalence of fever in clinical settings is vast, affecting patients across different age groups and health statuses. In pediatric populations, fever is one of the most common reasons for emergency department visits, while in adults, it may indicate serious conditions such as sepsis, pneumonia, or other infections. The etiology of fever can be complex, requiring healthcare professionals to recognize and evaluate various factors, including the patient's medical history, clinical presentation, and associated symptoms. Timely and accurate assessment of fever is critical to determining the appropriate interventions and treatments [2].

Nursing assessment of fever includes a systematic approach to monitoring vital signs, correlating

laboratory test results, and performing a thorough physical examination. Nurses utilize various methods to accurately measure body temperature, including mercury thermometers, electronic thermometers, infrared thermometers, and tympanic thermometers. Each method varies in accuracy and convenience, making the choice of technique essential for effective patient care. Additionally, understanding the patient's baseline temperature, previous medical conditions, and potential sources of infection is fundamental to a comprehensive nursing assessment [3].

Beyond assessment, nurses are involved in implementing interventions aimed at managing fever and addressing its underlying causes. Intervention strategies may range from pharmacological approaches, such as administering antipyretics like acetaminophen or ibuprofen, to non-pharmacological methods including tepid sponge baths, increased fluid intake, and appropriate patient education. The choice of intervention often depends on the patient's age, coexisting health issues, the severity of fever, and the overall clinical picture [4].

The dynamic nature of fever demands that nurses maintain a vigilant and adaptable approach in their practice. Implementation of evidence-based guidelines is essential in fostering effective nursing care and improving patient outcomes. Relevant literature and research have generated a wealth of knowledge regarding the pathophysiology and management of fever, providing critical insights that inform nursing assessment and interventions. Furthermore, the implications of fever extend beyond immediate physical responses, often affecting a patient's psychological well-being and comfort level, thus highlighting the holistic nature of nursing care [5].

Fever Assessment: Methods and Best Practices:

Fever is often one of the first signs of illness, representing a complex physiological response to infection, inflammation, or other health conditions. The assessment of fever is an essential component of clinical practice across various healthcare settings, including hospitals, outpatient clinics, and at-home care. Accurate and timely fever assessment not only assists in diagnosing a patient's condition but also guides subsequent treatment decisions [6].

Fever is defined as an elevation of body temperature above the normal range, typically considered to be around 36.1°C to 37.2°C (97°F to 99°F) when

measured orally. A fever is generally accepted to occur when the body temperature rises above 38.0°C (100.4°F). While fever can be a sign of an underlying pathology, it is often a natural response of the immune system, helping to fight infections by creating an environment less conducive to pathogen growth [7].

Methods of Fever Assessment

Accurate fever assessment relies on various methods of temperature measurement. Selecting the appropriate method can depend on factors such as the patient's age, the required accuracy, and the setting in which the measurement is taken [7].

1. Oral Thermometers

Oral thermometers are commonly used for fever assessment in children and adults, particularly when they can cooperate and hold the thermometer under their tongues. Digital oral thermometers typically provide precise readings within a few seconds.

2. Rectal Thermometers

Rectal thermometers are often considered the gold standard for assessing body temperature, especially in infants and young children. They provide accurate core body temperature readings; however, their use can be uncomfortable and may lead to concerns about privacy and anxiety for the patient [8].

3. Axillary Thermometers

Axillary temperature measurement involves placing the thermometer in the armpit. While this method is non-invasive and easy to perform, it is known to be less accurate than rectal or oral measurements and is often considered less reliable for diagnosing fever.

4. Tympanic Thermometers

Tympanic thermometers measure temperature via infrared sensors in the ear canal. They are quick and generally comfortable, making them suitable for both adults and children. However, factors such as earwax or improper positioning can affect accuracy, leading to inconsistent results.

5. Temporal Artery Thermometers

Temporal artery thermometers measure infrared heat from the temporal artery on the forehead. This method is non-invasive and painless, providing results rapidly. Although they can be convenient in a clinical setting, they are sensitive to environmental factors, such as ambient temperature and

measurement technique, which may impact the accuracy of readings [9].

6. Invasive Monitoring

Invasive methods such as central venous catheters or intra-arterial monitoring can be used in critically ill patients to provide accurate core temperature readings. However, such methods are generally reserved for intensive care settings due to their complexity and potential for complications [9].

Importance of Accurate Measurement

Accurate fever assessment is crucial for several reasons:

1. **Diagnostic Value:** Fever can indicate various underlying conditions, ranging from benign viral infections to severe bacterial infections and other systemic diseases. Accurate temperature readings contribute significantly to developing differential diagnoses [10].
2. **Clinical Decision-Making:** The degree of fever can guide clinical actions, including the need for further testing, initiation of antibiotic therapy, or hospital admission. Misinterpretation of fever status may lead to inappropriate management, potentially worsening the patient's condition.
3. **Monitoring Response to Treatment:** Tracking changes in body temperature over time helps evaluate treatment efficacy and disease progression, allowing for timely adjustments in the management plan [10].

Challenges in Fever Assessment

Despite the availability of numerous methods for fever assessment, healthcare practitioners encounter several challenges:

1. **Variability in Technique:** Inconsistent measurement techniques among healthcare professionals can result in significant variability in temperature readings. Adhering to standardized protocols is vital to mitigate discrepancies [11].
2. **Patient Factors:** Factors such as age, level of hydration, and environmental conditions can impact body temperature. For instance, febrile responses can be blunted in elderly patients or those on antipyretic

medications, making diagnosis more challenging.

3. **Limitations of Temperature Devices:** Device accuracy can vary depending on the type and quality of the thermometer. Healthcare facilities should regularly calibrate their equipment and consider the nuances associated with each method [11].
4. **Cultural Differences:** Cultural beliefs and practices may influence how fever is perceived and treated, which can affect patient interactions and compliance with recommended assessments [12].

Best Practices for Fever Assessment

To enhance the accuracy and reliability of fever assessment, the following best practices can be implemented in clinical and home settings:

1. **Standardization of Protocols:** Establishing clear guidelines for the method of temperature measurement reduces inconsistencies. Training staff on the correct techniques and device usage is essential [13].
2. **Selection of the Appropriate Method:** Choosing the correct method based on the patient's age, condition severity, and environment improves accuracy. For critically ill patients, invasive methods may be warranted, while non-invasive methods may suffice for stable individuals.
3. **Timely and Frequent Monitoring:** Monitoring temperature at regular intervals provides insights into the patient's response to treatment and disease progression, allowing healthcare providers to make informed decisions promptly.
4. **Patient Education:** Educating patients and caregivers about the significance of accurate temperature monitoring and how to perform it correctly fosters better engagement in their care.
5. **Documentation and Communication:** Accurate documentation of temperature readings in medical records is critical for continuity of care. Clear communication among healthcare teams regarding a patient's fever status and associated

symptoms helps facilitate comprehensive management [13].

Identifying the Underlying Causes of Fever:

Fever, defined as an elevation in body temperature above the normal range (typically around 98.6°F or 37°C), serves as a common physiological response to various underlying health conditions. It acts as a defense mechanism, indicating the body's attempt to combat infections and other diseases. Consequently, understanding the underlying causes of fever is paramount in clinical practice, as it helps healthcare professionals devise appropriate treatment plans [14].

Infectious Causes

Infectious agents are among the most common causes of fever. The types of infections can be broadly categorized into viral, bacterial, fungal, and parasitic origins.

1. **Viral Infections:** Viruses are the leading culprits behind febrile illnesses. Common examples include influenza, common colds, and more serious conditions like COVID-19, dengue fever, and viral hepatitis. The mechanism of fever in viral infections often involves endogenous pyrogens, such as interleukin-1 (IL-1), which are produced by immune cells in response to viral invaders [15].
2. **Bacterial Infections:** Bacterial infections often result in fever due to the proliferation of bacteria and the immune response they elicit. Examples include streptococcal throat infections, urinary tract infections (UTIs), and pneumonia. Furthermore, certain severe bacterial infections, such as sepsis, can provoke a hyperthermic response that can be life-threatening if not promptly addressed.
3. **Fungal and Parasitic Infections:** Fungi, such as those causing histoplasmosis and candidiasis, as well as parasites, like malaria and toxoplasmosis, can also cause significant fever. The immune response triggered by these pathogens typically involves the release of pyrogens that induce fever as a defense mechanism to inhibit the growth of the infecting organism [15].

Inflammatory Diseases

Apart from infections, fever can be a significant sign in numerous autoimmune and inflammatory disorders. Conditions like rheumatoid arthritis, systemic lupus erythematosus (SLE), and inflammatory bowel disease (IBD) exemplify how the body's immune system, in its state of dysregulation, can produce fever-inducing substances [16].

In autoimmune diseases, the body produces antibodies against its tissue, leading to numerous inflammatory processes. The cytokines released during these processes—specifically interleukins and tumor necrosis factor-alpha (TNF- α)—often trigger fever. Consequently, fever can serve as an indicator of the severity or activity of such autoimmune conditions [16].

Malignancies

Fever can also serve as a harbinger of certain cancers. Malignancies, particularly hematological malignancies such as leukemia and lymphoma, frequently present with fever as a symptom. The cancer cells secrete pyrogenic cytokines that lead to fever, and persistent or unexplained fevers in a patient can often signal an underlying malignancy. In cancer-related fever, the body's immune response plays a crucial role, albeit sometimes inappropriately or excessively, thereby leading to febrile episodes [17].

Non-Infectious Causes

In addition to the infectious and inflammatory origins, fever can arise from non-infectious causes, including:

1. **Medications:** Drug-induced fever is not uncommon and can stem from various medications, including antibiotics, anticonvulsants, and nonsteroidal anti-inflammatory drugs (NSAIDs). The fever can occur due to direct drug effects or immune-mediated processes and typically resolves upon discontinuation of the offending medication [18].
2. **Thyroid Dysfunction:** Hyperthyroidism can lead to fever due to increased metabolic activity. The enhancement of basal metabolic rate can cause the body's temperature-setting mechanism to elevate, resulting in episodic or persistent fever.

3. **Heat-Related Illness:** Heat exhaustion and heatstroke present with various symptoms, including fever, due to exposure to excessively high temperatures. In such cases, the body's thermoregulatory mechanisms are overwhelmed.
4. **Vaccine Reactions:** Post-vaccination fever is a common phenomenon seen with many immunizations, particularly in children. This immune response arises as the body mounts a protective response to the antigens introduced by the vaccine [19].

Identifying the Cause

The process of identifying the underlying cause of a fever involves a thorough patient history, physical examination, and often a series of laboratory and diagnostic tests. Physicians typically consider various aspects, such as the duration of the fever, the pattern (e.g., continuous, intermittent, remittent), associated symptoms (e.g., cough, rash, fatigue), travel history, exposure risks, and vaccination status [20].

Laboratory tests may include complete blood counts, blood cultures, urine tests, imaging studies, and specific serologies, depending on the suspected cause. The ability to differentiate between a benign fever due to viral infections and a more serious condition like sepsis or malignancy is a critical aspect of medical practice [20].

Clinical Implications of Fever in Nursing Practice:

Fever, defined as an increase in body temperature beyond the normal range, is a common physiological response indicating infection, inflammation, or other pathophysiological processes. In nursing practice, the significance of fever extends beyond its definition; it serves as a critical clinical indicator that informs patient assessment, diagnosis, treatment planning, and overall management. Understanding the clinical implications of fever is essential for nurses as they navigate patient care in diverse healthcare settings [21].

Fever typically occurs as a response to pyrogens—substances that induce fever. Pyrogens can be either exogenous, originating from outside the body (such as bacteria, viruses, or toxins), or endogenous, produced by the body in response to pathogens or inflammatory stimuli. The hypothalamus, a critical component of the body's thermoregulatory center,

plays a pivotal role in modulating body temperature. When pyrogens trigger the inflammatory response, cytokines such as interleukin-1 (IL-1) and tumor necrosis factor-alpha (TNF- α) are released, prompting the hypothalamus to raise the body's set point temperature. This elevation results in the classic symptoms of fever, including increased heart rate, malaise, and a general sense of discomfort [22].

Fever serves multiple clinical purposes. It is a protective mechanism that enhances immune function. By raising the body temperature, fever can inhibit pathogen reproduction and promote the activity of immune cells such as lymphocytes and macrophages. Consequently, while fever is often viewed negatively by patients, it is important to recognize that it can also play a significant role in the body's defense against infection [23].

In a clinical context, fever serves as a prognostic indicator and can guide healthcare professionals in diagnosing and evaluating the severity of a condition. A sudden onset of fever, for example, may alert nurses to infection and necessitate prompt interventions such as blood cultures or initiation of broad-spectrum antibiotics. Moreover, persistent fever can indicate complications or new diagnoses, urging further investigative actions such as imaging studies or specialized consultations [24].

Nurses play a vital role in the comprehensive assessment and management of patients with fever. The first step involves accurate measurement of body temperature using appropriate devices, such as tympanic, oral, rectal, or infrared thermometers. Each method has its merits and limitations, and the choice of method may depend on patient age, condition, and the clinical setting. Monitoring temperature regularly helps track the progression and resolution of fever and ensures timely interventions [25].

The assessment of a patient with fever should extend beyond temperature measurement to include evaluating accompanying signs and symptoms, patient history, and potential sources of infection. The severity and duration of fever, the pattern of temperature fluctuations, and associated symptoms such as chills, sweats, or rigors are crucial factors influencing the nursing assessment. Nurses should also consider examining potential underlying conditions, such as recent travel history, exposure to infectious diseases, or chronic health issues, which could provide insight into the etiology of the fever [26].

In terms of management, nursing interventions may encompass both pharmacological and non-pharmacological strategies. Antipyretics such as acetaminophen or ibuprofen often play a primary role in fever management, especially when fever results in discomfort or poses a risk for further complications. Non-pharmacological strategies, including adequate hydration, maintaining a comfortable environment, and appropriate clothing, can effectively help mitigate fever symptoms. Additionally, patient education on the nature of fever, its implications, and the importance of adherence to prescribed treatments is a key component of nursing care [27].

The management of fever presents numerous implications for nursing practice in terms of patient care and education. Education forms a cornerstone of enhancing patient knowledge and compliance. Nurses have the responsibility of informing patients and their families about the meaning of fever, its potential significance, and appropriate responses to elevated temperatures. Engaging in conversations about the importance of prompt reporting of concerning symptoms is vital, as it can lead to early detection of complications, such as sepsis [28].

Culturally competent nursing care is also essential when educating patients about fever, as beliefs about illness and treatment may vary across different cultures. Nurses must be aware of these cultural perspectives and tailor their educational approaches to ensure that patients feel respected and understood [28].

Moreover, fever management emphasizes the importance of interdisciplinary collaboration. Nurses should work closely with other healthcare professionals, including physicians and pharmacists, to ensure comprehensive care and effective treatment plans are developed. Regular communication among members of the healthcare team enhances patient safety and care continuity, particularly in acute care or critical care settings, where temperature fluctuations may signal rapid changes in patient status [29].

Nursing Interventions for Fever Management:

Fever, defined as an elevated body temperature above the normal range, is a common physiological response that signifies an underlying condition, often an infection. While it is a natural defense mechanism that can aid in fighting off pathogens, persistent or high fevers may be detrimental, particularly in vulnerable populations such as

infants, the elderly, and patients with weakened immune systems. Nurses play a critical role in the management of fever, employing various interventions to alleviate discomfort, mitigate potential complications, and address the root causes of the elevated temperature [30].

Assessment

The first step in fever management is a comprehensive assessment. Nurses are responsible for obtaining a thorough patient history and performing a physical examination to ascertain the fever's etiology. Key components of the assessment include measuring body temperature using appropriate methods, such as oral, rectal, tympanic, or axillary thermometers, while considering the patient's age and clinical condition. The normal body temperature can fluctuate based on various factors, so nurses must analyze temperature trends rather than relying on a single measurement [30].

Additionally, a detailed symptom assessment can provide clues to the cause of the fever. Nurses should inquire about associated symptoms such as chills, night sweats, headache, body aches, malaise, and any recent medical history, including infections or use of medications. Patients who are immunocompromised or have chronic illnesses may require special attention, as they could exhibit atypical fever presentations. Monitoring vital signs, including heart rate and respiratory rate, is also pivotal, as fever can provoke tachycardia and increased metabolic demands on the body [31].

Pharmacological Treatment

Pharmacological interventions are essential in managing fever, especially when it becomes uncomfortable or poses a risk of complications. The nursing role encompasses the safe administration of antipyretic medications, such as acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), which can alleviate fever and discomfort [32].

Nurses are responsible for assessing the patient's overall medication profile to prevent potential drug interactions, particularly in older adults who often take multiple medications. They should educate patients and families about the importance of adhering to recommended dosages and the timing of these medications. For instance, patients should be informed about the onset of action and peak effects to optimize the timing of administration in relation to fever spikes [32].

In some cases, the underlying cause of fever might require treatment with antibiotics or antivirals. Nurses facilitate this process by collecting specimens for laboratory analysis, such as blood cultures or urinalysis, and ensuring timely initiation of therapy while closely monitoring the patient's response [33].

Non-Pharmacological Strategies

In addition to pharmacological measures, non-pharmacological interventions play a pivotal role in fever management. These strategies often focus on patient comfort and maintaining fluid balance, given the risk of dehydration during febrile episodes. Nurses should implement cooling measures, such as utilizing tepid sponge baths or applying cool compresses to the forehead, neck, and axillary regions. These interventions can help reduce body temperature in a safe, gradual manner while providing symptomatic relief [34].

Nurses must also emphasize the importance of hydration. Patients with fever are at an increased risk of dehydration due to increased metabolic demands and potential fluid loss from sweating. Encouraging oral fluid intake or administering intravenous fluids, if necessary, is vital. Nurses should monitor fluid balance, including input and output, and be vigilant for signs of dehydration such as dry mucous membranes, decreased urine output, or altered mental status [35].

Additionally, appropriate clothing and environmental adjustments should be made. Patients may experience chills or overheating depending on their fever's progression. Nurses should allow for the patient to be comfortably dressed and consider modifying room temperature and ventilation to enhance patient comfort [36].

Patient Education

Holistic nursing care extends beyond immediate interventions to encompass education that empowers patients and their families. Nurses should provide comprehensive education regarding the nature of fever and its potential causes, helping patients understand when to seek further medical advice. For instance, patients may be counseled on recognizing warning signs such as persistent high fever, severe headache, rash, or difficulty breathing, which may necessitate immediate medical attention [37].

Moreover, educating patients about the appropriate use of antipyretics, including potential side effects

and when it is appropriate to use non-pharmacological methods, is essential. Understanding the fever's implications and management can decrease patient anxiety and promote cooperation with the treatment plan [37].

In the event that the fever is associated with a chronic condition, such as malignancies or autoimmune disorders, education on recognizing patterns of fever and associated symptoms can empower patients in self-monitoring and managing their own health more effectively [38].

Monitoring and Documentation of Fever in Patient Care:

Fever is one of the most common clinical signs that indicates an ongoing physiological process in the body, often signaling infection or inflammation. It is a critical parameter in the assessment of a patient's health status. Monitoring and documenting fever accurately is essential in patient care, as it enables healthcare professionals to make informed decisions regarding diagnosis, treatment, and monitoring of patients [39].

Fever, defined as an elevation of body temperature above the normal range, is often subjective, with most healthcare professionals considering a temperature above 100.4°F (38°C) as feverish. Various factors can influence body temperature, including time of day, level of physical activity, medication, and hydration status. Therefore, monitoring fever is not only crucial for identifying potential underlying conditions but also for evaluating the effectiveness of therapeutic interventions [39].

In many clinical settings, fever serves as a key indicator of infection, especially in vulnerable populations such as pediatrics, geriatrics, and immunocompromised patients. Fever can help healthcare teams identify serious conditions such as sepsis or pneumonia early, allowing for timely interventions. Regular monitoring of body temperature is also essential in postoperative patients to detect complications such as infections or inflammatory responses that may arise post-surgery [40].

Methods of Monitoring Fever

Fever can be monitored using various techniques, including oral, rectal, axillary, tympanic, and temporal artery thermometry. Each of these methods has different levels of accuracy, convenience, and

appropriateness depending on the patient's age, condition, and stage of care.

1. **Oral Thermometry:** This method involves placing a thermometer in the mouth, making it suitable for cooperative adults and children. It is a widely accepted method but can be influenced by eating, drinking, or smoking shortly before the measurement.
2. **Rectal Thermometry:** Considered the gold standard for accuracy, rectal thermometry is often utilized in infants and in cases where precise readings are necessary, despite being uncomfortable.
3. **Axillary Thermometry:** This method is less invasive and easier to perform but is known for providing lower temperature readings compared to other methods.
4. **Tympanic and Temporal Artery Thermometry:** Both methods offer high-speed readings and convenience, particularly in emergency settings. The tympanic thermometer measures infrared radiation from the tympanic membrane, while the temporal artery thermometer assesses temperature from the forehead [40].

Each monitoring method has advantages and limitations, which healthcare providers must consider when selecting the appropriate technique for each patient scenario.

The Role of Documentation

Accurate documentation of fever is a cornerstone of effective patient care and communication among healthcare providers. Documenting the temperature and any associated parameters (such as time of measurement, patient's symptoms, and any interventions) provides a comprehensive overview of the patient's status. Well-documented fever records can aid in identifying trends in a patient's health and responding to changes collaboratively [41].

Documentation should include details such as the method of measurement, specific temperature readings, accompanied symptoms (e.g., chills, sweating, lethargy), and the times of occurrences. Additionally, noting the patient's medical history, current medications, and recent surgeries can offer insight into the potential causes of the fever. This

information is critical not just for the treating physician but also for any other healthcare personnel involved in the patient's care.

The advent of technology has significantly enhanced the monitoring and documentation of fever. Electronic health records (EHRs) facilitate seamless integration of temperature data with other clinical information, allowing for real-time tracking and easier access to patient history for healthcare providers. Many systems alert providers when a patient's temperature reaches critical thresholds, ensuring timely interventions [41].

Moreover, wearable technology, such as smartwatches and health monitors, provide continuous body temperature tracking. These devices can send data directly to healthcare professionals or alert patients to fluctuations in temperature, promoting proactive healthcare management. Telemedicine, accelerated by the demands of the COVID-19 pandemic, also incorporated mobile applications that allow patients to self-monitor and report their symptoms, including fever, thereby increasing accessibility to healthcare [42].

The systematic monitoring and documentation of fever can substantially improve patient outcomes. Timely identification of fever can lead to quicker diagnoses, more effective treatment plans, and reduced hospital stays. In emergency and critical care settings where every second counts, early detection of fever-related conditions can be life-saving. Comprehensive documentation ensures continuity of care and supports clinical decision-making, ultimately enhancing patient safety and satisfaction [42].

In terms of clinical workflows, establishing protocols for fever monitoring can streamline processes, clarify responsibilities among staff, and ensure consistent practices across various healthcare settings. Training staff on the importance and methods of monitoring fever, along with proper documentation, can foster a culture of attentive patient care [43].

Patient Education and Family Involvement in Fever Management:

Fever is a common physiological response to infection or illness, characterized by an elevation in body temperature. While fever itself is usually not dangerous, it can be indicative of underlying health conditions and often generates anxiety among

patients and families. Effective fever management is crucial not only to alleviate discomfort but also to reduce potential complications associated with elevated temperatures. Given the proactive role that families can play in managing fever, patient education and family involvement are essential components in ensuring effective care [44].

Before delving into patient education and family involvement, it is essential to understand what fever is. The human body maintains a normal temperature around 98.6°F (37°C), regulated by the hypothalamus. Fever occurs when the body's regulatory set point is temporarily increased in response to factors such as infections, inflammation, or other medical conditions. While fever is generally a natural defense mechanism aiming to help the body combat pathogens, the associated discomfort can lead to concerns for patients and their families [45].

Importance of Patient Education

Patient education is a vital aspect of healthcare. It empowers patients and their families with the knowledge required to manage symptoms effectively. For fever management, education involves informing patients and caregivers about what a fever is, how to recognize it, when to seek medical attention, and the various methods available for managing it [46].

1. **Recognizing Fever:** Educating families about how to accurately measure body temperature—using thermometers appropriately—can prevent unnecessary panic. Different methods (oral, rectal, tympanic, axillary) offer varying degrees of accuracy and sensitivity, and understanding these can facilitate proper assessment [47].
2. **Understanding when to seek help:** Parents and caregivers often grapple with determining when a fever warrants medical attention. Clear guidelines—such as age-related thresholds, duration of fever, accompanying symptoms (such as rash, difficulty breathing, or persistent vomiting), and pre-existing health conditions—should be provided to assist families in making informed decisions.
3. **Fever Myths and Misconceptions:** Myths surrounding fever abound, leading many to either overreact or underreact when faced

with a feverish child. Through education, patients and families can distinguish between myths and facts (e.g., the belief that a high fever always indicates a serious infection). Understanding that not all fevers necessitate medical intervention can alleviate anxiety and promote rational responses [48].

4. **Home Care Strategies:** Effective fever management often includes home care strategies, such as administering appropriate doses of antipyretics (like acetaminophen or ibuprofen) and providing physical comfort through hydration, clothing adjustment, and cooler environments. Teaching families how and when to employ these strategies promotes active participation in care [48].
5. **Communication with Healthcare Professionals:** Educating patients about how to communicate effectively with healthcare providers can facilitate better management of fever. Families must learn to articulate symptoms clearly and provide relevant history to enable more accurate diagnoses and treatment plans [49].

Family Involvement in Fever Management

Familial involvement in healthcare is pivotal, particularly in managing children's fevers, where parents are typically the first line of response. The active participation of families can lead to more effective management and a better overall experience for both patients and caregivers.

1. **Support Systems:** Family members can provide emotional reassurance and physical comfort, which is especially beneficial for children experiencing fever. The presence of supportive family members can reduce anxiety and promote a sense of security, thereby enhancing the overall health experience [50].
2. **Monitoring Symptoms:** Involving family members in the continuous assessment of fever trends and symptoms plays an essential role in health monitoring. Logkeeping can help identify patterns that can be shared with healthcare providers, allowing for informed decisions regarding medical interventions.

3. **Education as a Collective Effort:** Engaging families in the education process amplifies the effectiveness of information dissemination. Family meetings, workshops, and demonstration sessions can facilitate a group understanding of fever management, thereby strengthening the support network for the patient [50].
4. **Decision-Making:** Families should be seen as a part of the decision-making team. Encouraging them to voice concerns, preferences, and insights creates a collaborative environment. This approach acknowledges the unique contextual knowledge families have about the patient's habits, reactions, and history.
5. **Reinforcing Care Plans:** Families can bolster compliance with care plans through reminders and encouragement. When caregivers are knowledgeable, they can consistently apply home care strategies recommended by healthcare providers, thus ensuring continual management of fever and related symptoms [50].

Challenges and Solutions

Despite the clear importance of patient education and family involvement in fever management, obstacles can arise. These may include health literacy disparities, cultural differences in understanding fever, and varying degrees of access to healthcare resources.

1. **Addressing Health Literacy:** Healthcare providers must strive to customize educational materials to suit the diverse backgrounds and literacy levels of patients and families. Utilizing visuals, simple language, and culturally relevant examples can enhance comprehension [51].
2. **Cultural Sensitivity:** Recognizing cultural attitudes toward fever and healthcare practices is essential. Open discussions with families regarding their beliefs and preferences can bridge gaps and foster collaborations in fever management [52].
3. **Access to Resources:** Ensuring equitable access to healthcare services, including educational materials and support systems, is crucial. Community health initiatives that focus on educating families about

fever management and providing resources can address these disparities [53].

Collaborative Care: Interdisciplinary Approaches to Fever Treatment:

Fever, a common physiological response to illness, serves as an important diagnostic indicator in the medical field. It is characterized by an elevation of body temperature, typically above 100.4°F (38°C), and often signifies underlying infections or inflammatory processes. Traditional approaches to fever management primarily involve antipyretic medications such as acetaminophen or ibuprofen. However, managing fever, particularly in complex cases that require nuanced understanding and intervention, benefits significantly from collaborative care involving interdisciplinary teams [54].

Before delving into strategies for fever treatment, it is essential to understand fever as a clinical symptom rather than a condition requiring treatment in isolation. Fever is not inherently detrimental; in fact, it plays a crucial role in the immune response by creating an environment less hospitable to pathogens. Fever can inhibit bacterial growth and enhance the activity of immune cells, which makes its management context-dependent. Thus, the rationale for treatment often involves not only reducing temperature for patient comfort but also considering the underlying cause, which may vary from viral infections to more serious conditions such as sepsis [55].

The Role of Interdisciplinary Collaboration

Interdisciplinary collaboration in fever management involves a team of healthcare professionals—physicians, nurses, pharmacists, dietitians, physical therapists, and social workers—who work together to provide comprehensive care. This approach enables the integration of various skill sets and perspectives, fostering holistic management. For example, while physicians may focus on diagnosing the underlying cause of fever and determining appropriate treatments, nurses can monitor patient symptoms and reactions, and pharmacists can ensure the safe administration of medications while avoiding contraindications due to other prescriptions the patient may be taking [56].

1. **Physicians:** The role of physicians in fever management is critical. They carry out the initial assessment, which includes taking a detailed history, performing a physical

examination, and ordering relevant investigations such as blood tests, cultures, or imaging studies. Their medical acumen is essential for determining the most appropriate treatment strategy, especially in cases of suspected serious infections [57].

2. **Nursing Staff:** Nurses provide frontline care and support, monitoring patients' vital signs, administering medications, and offering comfort measures. Their observations can yield insightful data that informs the medical team's decisions. Moreover, nurses play an integral role in educating patients and families about fever and its implications, promoting adherence to treatment regimens and recommending home care strategies during recovery [58].
3. **Pharmacists:** In managing fever, the pharmacist's role extends beyond dispensing medications to include ensuring that prescribed treatments are appropriate and effective. They can provide crucial information about potential drug interactions, advise on dosages, and help patients understand when to utilize antipyretics versus seeking further medical care [59].
4. **Dietitians:** Fever can lead to increased metabolic demand and dehydration; thus, dietitians play a vital role in ensuring adequate hydration and nutrition. They can provide tailored dietary advice that supports recovery by suggesting foods that are easy to digest and rich in necessary nutrients.
5. **Physical Therapists:** In cases where fever might be associated with significant weakness or fatigue due to the underlying illness, physical therapists can assist patients in regaining strength and functionality through designed rehabilitation programs [60].
6. **Social Workers:** Often overlooked during acute care, social workers can help identify social determinants affecting patient health, such as access to healthcare and community resources, which are critical for effective recovery and ongoing health management [61].

Challenges of Interdisciplinary Collaboration

While the merits of collaborative care are clear, several challenges impede its effective implementation in fever management. Communication barriers often arise due to differing terminologies and priorities among healthcare professionals. Additionally, time constraints in acute care settings may limit interdisciplinary interactions, reducing opportunities for team-based decision-making. The presence of hierarchical structures within healthcare environments can also inhibit free exchange of ideas, where input from non-physician team members might be undervalued [62].

Moreover, the need for adequate training on teamwork and collaboration strategies is essential but often lacking in many medical education programs. This gap can limit healthcare professionals' confidence in working within interdisciplinary teams, potentially compromising the overall quality of care [63].

Benefits of Collaborative Care in Fever Management

Despite the challenges, interdisciplinary approaches to fever management yield several significant benefits:

1. **Comprehensive Assessment:** The presence of different professionals allows for a more thorough assessment and understanding of the patient's condition, leading to more accurate diagnoses and targeted treatments [64].
2. **Enhanced Patient Engagement:** Collaborative care places a strong emphasis on patient-centered approaches. Multidisciplinary teams help ensure that the patient feels supported and involved in their care decisions, leading to improved satisfaction and adherence to treatment plans.
3. **Holistic Care:** By addressing not only the physiological aspects of fever but also the emotional, social, and dietary needs of the patient, collaborative teams can deliver a more holistic form of management that supports overall well-being [65].
4. **Improved Outcomes:** Research demonstrates that interdisciplinary approaches can lead to reduced hospital

stays, fewer complications, and better adherence to prescribed therapies. For patients with complex fever diagnoses, such as those stemming from systemic conditions, collaborative care can be crucial in preventing relapses and addressing the underlying issues effectively [66].

5. **Education and Prevention:** Collaborative care teams are well-positioned to educate patients and their families about fever management, signs of potential complications, and preventive measures, thus fostering greater health literacy and autonomy [67].

Conclusion:

In conclusion, understanding fever is essential for nursing practice, as it serves as both a clinical sign and a potential indicator of underlying health issues. Through comprehensive nursing assessments—including accurate temperature measurement, thorough patient history, and consideration of clinical manifestations—nurses can effectively identify the etiology of fever and implement appropriate interventions. Managing fever requires a multifaceted approach, integrating pharmacological treatments, hydration, comfort measures, and patient education. Ongoing monitoring and documentation are critical in evaluating the effectiveness of interventions and making necessary adjustments to care plans.

Furthermore, collaboration with interdisciplinary teams enhances the quality of care and ensures that all aspects of the patient's health are addressed. By prioritizing education for patients and their families, nurses can empower them to understand fever management, recognize red flags, and engage actively in their care. Ultimately, a holistic understanding of fever, coupled with a robust assessment framework and targeted interventions, will improve patient outcomes, enhance comfort, and promote overall well-being.

References:

1. Albrecht RF, II, Wass CT, Lanier WL. Occurrence of potentially detrimental temperature alterations in hospitalized patients at risk for brain injury. *Mayo Clinic Proceedings*. 1998;73(7):629–635. doi: 10.1016/S0025-6196(11)64885-4.
2. High KP, Bradley SF, Gravenstein S, Mehr DR, Quagliarello VJ, Richards C, Yoshikawa TT. Clinical practice guideline for the evaluation of fever and infection in older adult residents of long-term care facilities: 2008 update by the Infectious Diseases Society of America. *Journal of the American Geriatrics Society*. 2009;57(3):375–394. doi: 10.1111/j.1532-5415.2009.02175.x.
3. Bruderlein U, Strupp P, Vagts DA. Fever in intensive care patients. *Anesthesiologie, Intensivmedizin, Notfallmedizin, Schmerztherapie*. 2006;41(7–8):E8–E18. doi: 10.1055/s-2006-925295.
4. Greer DM, Funk SE, Reaven NL, Ouzounelli M, Uman GC. Impact of fever on outcome in patients with stroke and neurologic injury: a comprehensive meta-analysis. *Stroke*. 2008;39(11):3029–3035. doi: 10.1161/STROKEAHA.108.521583.
5. Emmoth U, Mansson ME. Nursing care in fever – a literature study and intensive care nurses' viewpoint on nursing care and treatment of fever. *Vard Nord Utveckling Forsk*. 1997;17(4):4–8. doi: 10.1177/010740839701700402.
6. Axelrod P. External cooling in the management of fever. *Clinical Infectious Diseases*. 2000;31(Suppl. 5):S224–S229. doi: 10.1086/317516.
7. Childs C, Vail A, Protheroe R, King AT, Dark PM. Differences between brain and rectal temperatures during routine critical care of patients with severe traumatic brain injury. *Anaesthesia*. 2005;60(8):759–765. doi: 10.1111/j.1365-2044.2005.04193.x.
8. Diringer MN, Reaven NL, Funk SE, Uman GC. Elevated body temperature independently contributes to increased length of stay in neurologic intensive care unit patients. *Critical Care Medicine*. 2004;32(7):1489–1495. doi: 10.1097/01.ccm.0000129484.61912.84.
9. Hajat C, Hajat S, Sharma P. Effects of poststroke pyrexia on stroke outcome: a meta-analysis of studies in patients. *Stroke*. 2000;31(2):410–414. doi: 10.1161/01.str.31.2.410.
10. Adams HP, Jr, del Zoppo G, Alberts MJ, Bhatt DL, Brass L, Furlan A, Grubb RL, Higashida RT, Jauch EC, Kidwell C, Lyden PD, Morgenstern LB, Qureshi AI, Rosenwasser RH, Scott PA, Wijdicks EF.

- Guidelines for the early management of adults with ischemic stroke: a guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups: The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists. *Circulation*. 2007;115(20):e478–e534. doi: 10.1161/CIRCULATIONAHA.107.181486.
11. Jiang JY, Gao GY, Li WP, Yu MK, Zhu C. Early indicators of prognosis in 846 cases of severe traumatic brain injury. *Journal of Neurotrauma*. 2002;19(7):869–874. doi: 10.1089/08977150260190456.
12. Cairns CJ, Andrews PJ. Management of hyperthermia in traumatic brain injury. *Current Opinion in Critical Care*. 2002;8(2):106–110. doi: 10.1097/00075198-200204000-00003.
13. Edwards HE, Courtney MD, Wilson JE, Monaghan SJ, Walsh AM. Fever management practices: what pediatric nurses say. *Nursing & Health Sciences*. 2001;3(3):119–130. doi: 10.1046/j.1442-2018.2001.00083.x.
14. Edwards H, Walsh A, Courtney M, Monaghan S, Wilson J, Young J. Improving paediatric nurses' knowledge and attitudes in childhood fever management. *Journal of Advanced Nursing*. 2007;57(3):257–269. doi: 10.1111/j.1365-2648.2006.04077.x.
15. Alexander SE, Gallek M, Presciutti M, Zrelak P. SAH guideline. In: Thompson HJ, editor. *Care of the Patient with Aneurysmal Subarachnoid Hemorrhage*. American Association of Neuroscience Nurses; Glenview, IL: 2007.
16. Brain Trauma Foundation/American Association of Neurological Surgeons. Guidelines for the management of severe traumatic brain injury. *Journal of Neurotrauma*. 2007;24(Suppl. 1):S1–S106. doi: 10.1089/neu.2007.9999.
17. Cooper KE. *Fever and Antipyresis: The Role of the Nervous System*. Cambridge University Press; Cambridge: 1995.
18. Givens JL, Selby K, Goldfeld KS, Mitchell SL. Hospital transfers of nursing home residents with advanced dementia. *J Am Geriatr Soc*. 2012;60(5):905–9. doi: 10.1111/j.1532-5415.2012.03919.x.
19. Dwyer L, Harris-Kojetin L, Valverde R, Frazier J, Simon A, Stone N, Thompson N. Infections in long-term care populations in the United States. *J Am Geriatr Soc*. 2013;Mars 671(3):342–9. doi: 10.1111/jgs.12153.
20. Allemann H, Sund Levander M. Nurses' actions in response to nursing assistants' observations of signs and symptoms of infections among nursing home residents. *Nurs Open*. 2015;2(3):97–104. doi: 10.1002/nop2.22.
21. Büla CJ, Ghilardi G, Wietlisbach V, Petignat C, Francioli P. Infections and functional impairment in nursing home residents: a reciprocal relationship. *J Am Geriatr Soc*. 2004;52(5):700–6. doi: 10.1111/j.1532-5415.2004.52205.x.
22. Moyo P, Zullo AR, McConeghy KW, Bosco E, van Aalst R, Chit A, Gravenstein S. Risk factors for pneumonia and influenza hospitalizations in long-term care facility residents: a retrospective cohort study. *BMC Geriatr*. 2020;20(1):47. doi: 10.1186/s12877-020-1457-8.
23. High K, Bradley S, Gravenstein S, Mehr D, Quagliarello V, Richards C, Yoshinkawa TT. Clinical practice guideline for the evaluation of fever and infection in older adult residents of long-term care facilities: 2008 update by the infectious Diseases Society of America. *Clin Infect Dis*. 2009;48(2):149–71. doi: 10.1086/595683.
24. Moore A, McKelvie S, Glogowska M, Lasserson D, Hayward G. Infection in older adults: a qualitative study of patient experience. *Br J Gen Pract*. 2020;70(694):e312–21. doi: 10.3399/bjgp20X709397.
25. Eikelenboom-Boskamp A, Saris K, van Loosbroek M, Drabbe MIJ, de Jongh F, de Jong JWD, Boom-Poels PGM, Voss A. Prevalence of healthcare-associated infections in dutch nursing homes: follow-up 2010–2017. *J Hosp Infect*. 2019;101(1):49–52. doi: 10.1016/j.jhin.2018.08.011.
26. Limpawattana P, Phungoen P, Mitsungnern T, Laosuangkoon W, Tansangworn N. Atypical presentations of

- older adults at the emergency department and associated factors. *Arch Gerontol Geriatr.* 2016;62:97–102. doi: 10.1016/j.archger.2015.08.016.
27. Boockvar K, Gruber-Baldini A, Burton L, Zimmerman S, Magaziner J. Outcomes of infection in nursing home residents with and without early hospital transfer. *J Am Geriatric Soc.* 2005;53:590–6. doi: 10.1111/j.1532-5415.2005.53205.x.
28. Parameaswari P. Tool development in health care research. *J Med Allied Sci.* 2013;3(3):3–7.
29. Eriksson I, Gustafson Y, Fagerstrom L, Olofsson B. Prevalence and factors associated with urinary tract infections (UTIs) in very old women. *Int Psychogeriatr.* 2010;50:132–5. doi: 10.1016/j.archger.2009.02.013.
30. Schoevaerds D, Sibille FX, Gavazzi G. Infections in the older population: what do we know? *Aging Clin Exp Res.* 2021;33(3):689–701. doi: 10.1007/s40520-019-01375-4.
31. Mayne S, Bowden A, Sundvall PD, Gunnarsson R. The scientific evidence for a potential link between confusion and urinary tract infection in the elderly is still confusing - a systematic literature review. *BMC Geriatr.* 2019;19(1):32. doi: 10.1186/s12877-019-1049-7.
32. Boockvar K, Brodie H, Lachs M. Nursing assistants detect behaviour changes in nursing home residents that precede acute illness: development and validation of an illness warning instrument. *J Am Geriatric Soc.* 2000;48:1085–91. doi: 10.1111/j.1532-5415.2000.tb04784.x.
33. Boockvar K, Lachs M. Predictive value of nonspecific symptoms for acute illness in nursing home residents. *J Am Geriatric Soc.* 2003;51:1111–5. doi: 10.1046/j.1532-5415.2003.51360.x.
34. Sundvall P, Stuart B, Davis M, Roderick P, Michael M. Antibiotic use in the care home setting: a retrospective cohort study analysing routine data. *BMC Geriatr.* 2015;15(71):1–7. doi: 10.1186/s12877-015-0073-5.
35. Stocchetti N, Rossi S, Zanier ER, Colombo A, Beretta L, Citerio G. Pyrexia in head-injured patients admitted to intensive care. *Intensive Care Medicine.* 2002;28(11):1555–1562. doi: 10.1007/s00134-002-1513-1.
36. O'Grady NP, Barie PS, Bartlett JG, Bleck T, Carroll K, Kalil AC, Linden P, Maki DG, Nierman D, Pasculle W, Masur H. Guidelines for evaluation of new fever in critically ill adult patients: 2008 update from the American College of Critical Care Medicine and the Infectious Diseases Society of America. *Critical Care Medicine.* 2008;36(4):1330–1349. doi: 10.1097/CCM.0b013e318169eda9.
37. Natale JE, Joseph JG, Helfaer MA, Shaffner DH. Early hyperthermia after traumatic brain injury in children: risk factors, influence on length of stay, and effect on short-term neurologic status. *Critical Care Medicine.* 2000;28(7):2608–2615. doi: 10.1097/00003246-200007000-00071.
38. Wartenberg KE, Schmidt JM, Claassen J, Temes RE, Frontera JA, Ostapovich N, Parra A, Connolly ES, Mayer SA. Impact of medical complications on outcome after subarachnoid hemorrhage. *Critical Care Medicine.* 2006;34(3):617–623. doi: 10.1097/01.ccm.0000201903.46435.35.
39. Rosenberg JP, Yates PM. Schematic representation of case study research designs. *Journal of Advanced Nursing.* 2007;60(4):447–452. doi: 10.1111/j.1365-2648.2007.04385.x.
40. Reaven NL, Lovett JE, Funk SE. Brain injury and fever: hospital length of stay and cost outcomes. *Journal of Intensive Care Medicine.* 2009;24(2):131–139. doi: 10.1177/0885066608330211.
41. Kirkness CJ, Burr RL, Thompson HJ, Mitchell PH. Temperature rhythm in aneurysmal subarachnoid hemorrhage. *Neurocritical Care.* 2008;8(3):380–390. doi: 10.1007/s12028-007-9034-y.
42. Segatore M. Fever after traumatic brain injury. *Journal of Neuroscience Nursing.* 1992;24(2):104–109. doi: 10.1097/01376517-199204000-00010.
43. Polderman KH. Mechanisms of action, physiological effects, and complications of hypothermia. *Critical Care Medicine.* 2009;37(7 Suppl):S186–S202. doi: 10.1097/CCM.0b013e3181aa5241.
44. Thompson HJ, Kirkness CJ, Mitchell PH. Fever management practices of neuroscience nurses, part II: nurse, patient, and barriers. *Journal of Neuroscience Nursing.* 2007a;39(4):196–201. doi: 10.1097/01376517-200708000-00002.
45. McIlvoy L. The impact of brain temperature and core temperature on intracranial pressure and cerebral perfusion pressure. *Journal of Neuroscience Nursing.* 2007;39(6):324–331. doi: 10.1097/01376517-200712000-00002.
46. Laupland KB. Fever in the critically ill medical patient. *Critical Care Medicine.*

- 2009;37(7 Suppl):S273–S278. doi: 10.1097/CCM.0b013e3181aa6117.
47. Schulman CI, Namias N, Doherty J, Manning RJ, Li P, Alhaddad A, Lasko D, Amortegui J, Dy CJ, Dlugasch L, Baracco G, Cohn SM. The effect of antipyretic therapy upon outcomes in critically ill patients: a randomized, prospective study. *Surgical Infections* (Larchmt) 2005;6(4):369–375. doi: 10.1089/sur.2005.6.369.
48. Kilpatrick MM, Lowry DW, Firlik AD, Yonas H, Marion DW. Hyperthermia in the neurosurgical intensive care unit. *Neurosurgery*. 2000;47(4):850–855. doi: 10.1097/00006123-200010000-00011.
49. Sinuff T, Cook D, Giacomini M, Heyland D, Dodek P. Facilitating clinician adherence to guidelines in the intensive care unit: a multicenter, qualitative study. *Critical Care Medicine*. 2007;35(9):2083–2089. doi: 10.1097/01.ccm.0000281446.15342.74.
50. Thompson HJ, Tkacs NC, Saatman KE, Raghupathi R, McIntosh TK. Hyperthermia following traumatic brain injury: a critical evaluation. *Neurobiology of Disease*. 2003;12(3):163–173. doi: 10.1016/s0969-9961(02)00030-x.
51. Oeyen S. Closing the gap between knowledge and behavior: mission impossible? *Critical Care Medicine*. 2007;35(9):2219–2220. doi: 10.1097/01.CCM.0000281461.96109.4B.
52. Sund-Levander M, Grodzinsky E. The challenge of infections in frail elderly: the story of Mr Nilsson. *Clin Med Reviews Case Rep (CMRCS)* 2016, Online publication 2015-08-26.
53. Dahlberg L, Agahi N, Schön P, Lennartsson C. Planned and unplanned hospital admissions and their relationship with social factors: findings from a national, prospective study of people aged 76 years or older. *Health Serv Res*. 2018;53:4248–67.
54. Katz S, Ford AB, Moskiwitz W, Jaffe MW. Studies of illness in the aged. The index of ADL: a standardized measure of biological and psychosocial function. *JAMA*. 1963;185:914–9.
55. Mackowiak PA. Fever's upper limit. In: *Fever Basic Mechanisms and Management* Edited by Mackowiak PA, 2 edn. Philadelphia, New York: Lippincott Raven; 1997: 147–163.
56. Hulter Åsberg K. The ADL staircase (ADL-trappan). Lund: Studentlitteratur. In Swedish; 1990.
57. Yoshikawa TT, Reyes BJ, Ouslander JG. Sepsis in older adults in Long-Term Care Facilities: Challenges in diagnosis and management. *J Am Geriatr Soc*. 2019;67(11):2234–9.
58. Hair J, Black B, Babi nB, Anderson R, Tatham R. *Multivariate Data Analysis*. Upper Saddle River, NJ: Pearson Prentice Hall; 2006.
59. Masot O, Cox A, Mold F, Sund Levander M, Tingstrom P, Boersema GC, Botigué T, Daltrey J, Hughes K, Mayhorn C et al. Decision Support-Tools for early detection of infection in older people (aged > 65 years): a scoping review. *BMC Geriatrics* 2022, In press.
60. Hallgren J, Aslan A, Dhal Asan A. Risk factors for hospital readmission among Swedish older adults. *Eur Geriatr Med*. 2018;9:603–11.
61. Wolters A, Santos A, Llyod T. Emergency admissions to hospital from care homes: how often and what for? In. *Health Foundation*; 2019.
62. Tingström P, Milberg A, Rodhe N, Grodzinsky E, Sund-Levander M. Nursing assistants: he seems to be ill – a reason for nurses to take action: validation of the early detection scale of infection (EDIS). *BMC Geriatr*. 2015;15(122):2–10.
63. Sund-Levander M, Wahren LK. The impact of ADL-status, dementia, and body mass index on normal body temperature in elderly nursing home residents. *Arch Gerontol Geriatr*. 2002;35:161–9.
64. Liu A, Bui T, Van Nguyen H, Ong B, Shen Q, Kamalasena D. Serum C-reactive protein as a biomarker for early detection of bacterial infection in the older patient. *Age Ageing*. 2010;39(5):559–65.
65. Sund-Levander M, Grodzinsky E, Loyd D, Wahren LK. Error in body temperature assessment related to individual variation, measuring technique, and equipment. *Int J Nurs Pract*. 2004;10:216–23.
66. Tingström P, Milberg A, Sund-Levander M. Early nonspecific signs and symptoms of infection in institutionalized elderly persons: perceptions of nursing assistants. *Scandinavian J Nurs Sci*. 2010;24:24–31.
67. Kuma A. Review of the steps for development of quantitative Research Tools. *J Adv Pract Nurse*. 2015;1:103.