**Resuscitation / Stabilisation:**
- Nil By Mouth (NBM) if required
- Monitor vital signs as clinically indicated (BP, HR, T, RR, SpO2)
- Monitor pain assessment / score

**Bedside investigations:**
- BGL: If < 3mmol/L or > 20mmol/L notify SMO
- ECG: [as indicated] look for Arrhythmia, AMI
- Urinalysis / MSU: if urinary symptoms present
- Culture swab: (wounds, skin, throat, devices)

**Laboratory / Radiology:**
- **Pathology:** Refer to local nurse initiated STOP
  - FBC, UEC, LFTS, Coags, Glucose, Venous Lactate
  - Blood Cultures x 2 (if Temp ≥ 38.5°C or ≤ 35°C)
  - Urine βHCG if suspected pregnancy
- **Radiology:** Not generally indicated - refer to SMO

**Resuscitation / Stabilisation:**
- Oxygen therapy & cardiac monitor [as indicated]
- IV Cannulation (16-18gauge if unstable)
- IV Fluids: Sodium Chloride 0.9% I L IV stat versus over 8 hours (discuss with SMO)

**Symptomatic Treatment:**
- Analgesia: as per district standing order
- Antipyretic: as per nurse initiated medications
- IV Fluids: as per district standing order
- IV Antibiotics: within 60minutes if suspected sepsis

**Supportive Treatment:**
- Monitor neurological status GCS [as clinically indicated]
- Fluid Balance Chart (FBC)
- Cooling [as required]
**Practice Tips / Hints:**

- Elevated body temperature can be physiological, or caused by pathological processes such as infection, inflammatory processes, or malignancy.
- Fever is the body's natural response to infection. Raising the body temperature helps the body to fight off the infection, so it is not always necessary to treat the fever.
- Before an extensive work-up, the presence of fever should be confirmed and fever pattern documented.
- Typical signs and symptoms of infection are frequently absent in elderly patients, and as they age and becomes more frail, basal body temperature decreases, making it less likely that patients will achieve classic definitions of fever.
- Infection should be suspected in elderly patients with any of the following characteristics: decline in functional status, defined as new or increasing confusion, incontinence, falling, deteriorating mobility, reduced food intake, or failure to cooperate with staff.

**Further Reading / References:**


**Acknowledgements:** SESLHD Adult Emergency Nurse Protocols were developed & adapted with permission from:

- Murphy, M (2007) Emergency Department Toolkits. Westmead Hospital SWAHS
- Hodge, A (2011) Emergency Department Clinical Pathways. Prince of Wales Hospital SESLHD.

**Revision & Approval History:**

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<tr>
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