HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Nursing		
Document:	Internal Policy and Procedure		
Title:	Measurement of Temperature		
Applies To:	All Nursing Staff		
Preparation Date:	January 08, 2025	**Index No:**	NR-IPP-001
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1. PURPOSE:

1.1 To establish procedural guidelines for measurement of temperature.
1.2 To ensure high quality of nursing practice.
1.3 To enable the nurses to function in a consistent and standardized manner.

2. DEFINITONS:

2.1 **Temperature** is the difference between the amount of heat produced by the body and amount of heat loss.

3. POLICY:

3.1 The temperature will be assessed for the following reasons
- 3.1.1 Patient with any risk of temperature alterations.
- 3.1.2 Presence of signs and symptoms that may accompany temperature alterations; cold and clammy, warm or hot to touch, diaphoretic, shivering with chills and palpitations.
- 3.1.3 Factors that may influence temperature: age, stress, medications, environment, temperature changes, fever, heat stroke, hyperpyrexia, hyperthermia and hypothermia.
- 3.1.4 The most appropriate temperature measurement.

3.2 The routine duration for taking temperature is every 6 hours.
3.3 A patient at risk for temperature alteration, the duration for taking temperature is every 4 hours or as ordered by the physician.
3.4 Use electronic system for documentation in vital signs monitoring form during system shutdown return to manual Use BLUE ink pen and encircle 37°C in the vital signs chart. This is an acceptable guide in identifying the normal temperature reading. Affix RN initial and Job number at the bottom of each column.
3.5 If any error in recording is identified, do not use correction fluid. Cancel by drawing a line across the error and write "ME" and staff initial
3.6 Report to the physician any abnormal finding, reading or any signs or symptoms identified in alteration of body temperature.
3.7 The normal temperature 36.5–37.5◦C °C
rectal temperature, the most accurate reading, is usually 1° F (0.6° C) higher; axillary temperature, the least accurate, reads 1º te2° F (0.6° to 1.1° C) lower.

4. PROCEDURE:

4.1 Assess the patient for:
- 4.1.1 Any risk of temperature alterations
- 4.1.2 Assess for signs and symptoms that may accompany temperature alterations: cold, clammy, warm or hot to touch, diaphoretic, shivering with chills and palpitation.

4.1.3 Assess the factors that may influence temperature: age, stress, medications, environmental temperature changes heatstroke, hyperpyrexia, hyperthermia and hypothermia.

4.2 Prepare complete equipment. Ensure that the equipment is disinfected and clean.

4.3 Performs hand hygiene.

4.4 Explain the procedure to the patient.

4.5 Assist the patient in a comfortable and appropriate position.

4.6 Verify if the correct icon is properly selected by observing flashing of the icon on the instruments display.

4.7 Load a probe cover by inserting the probe into a probe cover and pressing the probe handle down firmly. In taking oral/ axillary temperature make sure to use the thermometer with blue probe well at the top of probe while in rectal use the red probe well.

4.7.1 Probe covers are single use only.

4.7.2 Do not re use probe cover, as this will result in inaccurate readings.

4.8 Obtain temperature reading via:

4.8.1 **Oral**

4.8.1.1 Ensure to ask the following to the patient before taking the oral temperature as it will interfere with the measurements for up to 20 min.

4.8.1.1.1 Ingesting hot or cold liquid

4.8.1.1.2 Eating

4.8.1.1.3 Chewing gums or mints

4.8.1.1.4 Brushing teeth

4.8.1.1.5 Mouth care

4.8.1.1.6 Smoking

4.8.1.1.7 Performing strenuous activity

4.8.1.2 Withdraw the probe to turn thermometer on.

4.8.1.3 Verify oral mode is selected by observing the flashing head.

4.8.1.4 Apply probe cover; wait for a short beep.

4.8.1.5 Place probe into sublingual.

4.8.1.6 Hold the probe in place without moving it; "walking segments" appears on screen, indicating measurement in progress.

4.8.1.7 Temperature result will appear in approximately 4 - 6 seconds. The display shows the measurement site, temperature scale, and patient reading for 30 seconds or until probe is replaced in the well.

4.8.1.8 Discard probe cover; never re-use.

4.8.1.9 Return probe to the probe well. The LCD display will go blank.

4.8.1.10 Record temperature reading on vital signs chart.

4.8.1.2 Withdraw the probe to turn thermometer on.

4.8.2 **Axilla**

4.8.2.1 Check the axillary region. It should be completely dry.

4.8.2.2 Inaccurate axillary measurement can be caused by:

4.8.2.2.1 Probe contact with clothing, bandages, electrodes, etc.

4.8.2.2.2 Poor tissue contact.

4.8.2.2.3 Prolonged exposure of the axilla to ambient air.

4.8.2.2.4 Forgetting to switch thermometer into proper axillary mode.

4.8.2.3 Withdraw the probe to turn thermometer on.

4.8.2.4 Press selection button to select the adult/pediatric axillary mode. The adult icon will have a flashing torso icon and pediatric icon is a drawing toddler.

4.8.2.4.1 Age range for using pediatric icon is 17 year and younger.

4.8.2.5 Apply probe cover.

4.8.2.6 Lift patient's arm, place probe as high as possible into the axilla in proper vertical position ('align with the spine') and place patients arm snugly down around probe. This must be performed against bare skin.

4.8.2.7 "Walking "segments will appear on the screen indicating measurement in progress.

4.8.2.8 Temperature result will appear in approximately 12-15 seconds. The display shows the measurement site, temperature scale, and patient reading for 30 seconds or until probe is replaced in the well.

4.8.2.9 Discard probe cover.

4.8.2.10 Return probe to the probe well. The LCD display will go blank.

4.8.2.11 Record temperature reading on vital signs chart.

4.8.3 **Rectal**

4.8.3.1 Keep patient's upper body and lower extremities covered with blanket.

4.8.3.2 Assist patient in lateral position, upper leg flexed.

4.8.3.3 Performs hand hygiene and use a disposable or clean gloves.

4.8.3.4 Separate the patient's buttocks with one hand and instruct to breathe slowly and relax while the probe is inserted.

4.8.3.5 Obtain the red probe well and probe with red ejection button.

4.8.3.6 Withdraw the probe to turn thermometer on.

4.8.3.7 Observes the icon with the lower half of the body flashing. Indicating rectal mode.

4.8.3.8 Apply probe cover. The use of lubricant is optional (if lubrication is needed, only use a small amount).

4.8.3.9 Insertion for an adult should be 5/8" (1.5cm) and less for infants and children.

4.8.3.10 "Walking" segments will appear on the screen indicating measurement in progress.

4.8.3.11 Temperature result will appear approximately 12-15 seconds. The display shows the measurement site, temperature scale and patient reading for 30 seconds or until probe is replaced in the well.

4.8.3.12 Discard probe cover.

4.8.3.13 Return probe to the probe well. The LCD display will go blank.

4.8.3.14 Record temperature reading on vital signs chart.

4.9 Notify the doctor for any abnormal findings in the alteration of body temperature.

5. MATERIALS AND EQUIPMENT:

5.1 Watch with second hand or digital display
5.2 Pen
5.3 Vital signs chart
5.4 Digital Thermometer
5.5 Thermometer Probe Covers
5.6 Alcohol swab

6. RESPONSIBILITIES:

6.1 Nurse

7. APPENDICES:

7.1 Vital signs chart

8. REFERENCES:

8.1 Ministry of Health, General Nursing Administration, Functions and Duties Policies and Procedures
8.2 Judith A. Schilling , H. Nancy Holemes , Lippincott's Nursing Procedures , fifth edition

9. APPROVALS:

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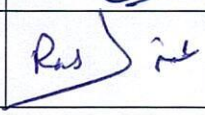
Approved by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 22, 2025

Appendix 7.1

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: _____ رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ سنة Years ☐ شهور Months ☐ يوم Days ☐ العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

VITAL SIGNS CHART

WEIGHT-kg						
POST-OPERATIVE DAY						
DATE						
TIME						
TEMPERATURE	40					
	39					
	38					
	37					
	36					
	35					
RESPIRATORY RATE						
O2 SATURATION						
BLOOD PRESSURE AND PULSE RATE PULSE = X SYSTOLIC = V DIASTOLIC = ^	240 220 200 180 160 140 120 100 80 60 40 20					
BP						
PAIN SCORE SCALE						
INITIALS AND JOB NUMBER						

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