

ASSESSMENT	DIAGNOSIS	PLANNING	NURSING INTERVENTION	RATIONALE	EVALUATION
<p>S: "Nurse parang mainit ang anak ko" as verbalized by the mother</p> <p>O: Temperature 38.9°C (+) Hot flushed skin, warm to touch</p> <p>RR: 47 bpm PR: 140 bpm</p>	<p>Hyperthermia related to presence of respiratory infection as manifested by temperature 38.9 °C</p>	<p>Short Term After 1 hour of proper nursing intervention, the patient's body temperature will decrease from 38.9 °C to 37.5 °C.</p> <p>Long Term After 4 hours of appropriate nursing intervention the patient's vital signs will return to normal range with 36.5-37.5 °C, pulse rate of 60-100, and respiratory rate of 12-20 beats per minute.</p>	<p>Independent</p> <ol style="list-style-type: none"> <li>1. Check vital signs</li> <li>2. Provide tepid sponge bath</li> <li>3. Provide well ventilated environment</li> <li>4. Advise to increase fluid intake</li> <li>5. Monitor vital signs and record for baseline data</li> </ol> <p>Dependent</p> <ol style="list-style-type: none"> <li>6. Provide antipyretic medications as indicated</li> </ol>	<ul style="list-style-type: none"> <li>• Vital signs provides more accurate indication of core temperature.</li> <li>• To lessen severe body heat</li> <li>• To promote heat loss.</li> <li>• To avoid dehydration.</li> <li>• To know the effectiveness of nursing interventions done.</li> <li>• This drug inhibits the prostaglandin that serve as mediators of pain and fever.</li> </ul>	<p>After 1 hour the temperature decrease from 38.9 to 37.5 °C The nursing intervention is fully met</p> <p>RR: 20 cpm PR: 100 bpm</p>

## NURSING CARE PLAN FOR FEVER

# Restorative Nursing Care Plans

**M Mark**



## **Restorative Nursing Care Plans:**

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