

ASSESSMENT	DIAGNOSIS	PLANNING	NURSING INTERVENTION	RATIONALE	EVALUATION
S: "Nurse parang mainit ang anak ko" as verbalized by the mother O: Temperature 38.9°C (+) Hot flushed skin, warm to touch RR: 47 bpm PR: 140 bpm	Hyperthermia related to presence of respiratory infection as manifested by temperature 38.9 °C	Short Term After 1 hour of proper nursing intervention, the patient's body temperature will decrease from 38.9 °C to 37.5 °C. 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.	Independent 1. Check vital signs 2. Provide tepid sponge bath 3. Provide well ventilated environment 4. Advise to increase fluid intake 5. Monitor vital signs and record for baseline data Dependent 6. Provide antipyretic medications as indicated	• Vital signs provides more accurate indication of core temperature. • To lessen severe body heat • To promote heat loss. • To avoid dehydration. • To know the effectiveness of nursing interventions done. • This drug inhibits the prostaglandin that serve as mediators of pain and fever.	After 1 hour the temperature decrease from 38.9 to 37.5 °C The nursing intervention is fully met RR: 20 cpm PR: 100 bpm

NURSING CARE PLAN FOR FEVER

Restorative Nursing Care Plan Samples

Chao Zhang



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Table of Contents Restorative Nursing Care Plan Samples

1. Understanding the eBook Restorative Nursing Care Plan Samples
 - The Rise of Digital Reading Restorative Nursing Care Plan Samples
 - Advantages of eBooks Over Traditional Books
2. Identifying Restorative Nursing Care Plan Samples
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Restorative Nursing Care Plan Samples
 - User-Friendly Interface
4. Exploring eBook Recommendations from Restorative Nursing Care Plan Samples
 - Personalized Recommendations

- Restorative Nursing Care Plan Samples User Reviews and Ratings
- Restorative Nursing Care Plan Samples and Bestseller Lists
- 5. Accessing Restorative Nursing Care Plan Samples Free and Paid eBooks
 - Restorative Nursing Care Plan Samples Public Domain eBooks
 - Restorative Nursing Care Plan Samples eBook Subscription Services
 - Restorative Nursing Care Plan Samples Budget-Friendly Options
- 6. Navigating Restorative Nursing Care Plan Samples eBook Formats
 - ePub, PDF, MOBI, and More
 - Restorative Nursing Care Plan Samples Compatibility with Devices
 - Restorative Nursing Care Plan Samples Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Restorative Nursing Care Plan Samples
 - Highlighting and Note-Taking Restorative Nursing Care Plan Samples
 - Interactive Elements Restorative Nursing Care Plan Samples
- 8. Staying Engaged with Restorative Nursing Care Plan Samples
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Restorative Nursing Care Plan Samples
- 9. Balancing eBooks and Physical Books Restorative Nursing Care Plan Samples
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Restorative Nursing Care Plan Samples
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Restorative Nursing Care Plan Samples
 - Setting Reading Goals Restorative Nursing Care Plan Samples
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Restorative Nursing Care Plan Samples
 - Fact-Checking eBook Content of Restorative Nursing Care Plan Samples

- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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