

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

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