

Fever Nursing Care Plan

Patient information	
Name: Lisa Carter	Age: 34
Medical record number: 87456321	Date of admission: July 27, 2024
Diagnosis	
Urinary tract infection, sepsis	
Nursing assessment and findings	
Vital signs	
Body temperature: 38.5°C	Heart rate: 110 bpm
Respiratory rate: 22 breaths/min	Blood pressure: 130/85 mmHg
Symptoms of bacterial infection?	Impaired thermoregulatory function?
<input checked="" type="radio"/> Yes <input type="radio"/> No	<input checked="" type="radio"/> Yes <input type="radio"/> No
Signs of acute brain injury?	
<input type="radio"/> Yes <input checked="" type="radio"/> No	
Nursing diagnosis	
Hyperthermia related to infection as evidenced by elevated body temperature, increased heart rate, and respiratory rate	
Nursing interventions	
<p>Monitor vital signs every 2 hours to assess the effectiveness of interventions. Administer antipyretics as prescribed to reduce fever. Provide tepid sponge baths to help lower body temperature. Ensure adequate fluid intake to prevent dehydration.</p> <p>Administer prescribed antibiotics to treat underlying infection. Encourage rest to help the body recover from infection. Use cooling blankets as needed to manage hyperthermia.</p> <p>Reassess temperature, heart rate, and respiratory rate after interventions.</p>	

Additional notes and documentation

Lisa has been responsive to antipyretics, but her temperature remains elevated.
Increased fluid intake has been encouraged, and IV fluids are administered as prescribed.
No signs of acute brain injury observed, but continuous monitoring is essential.
Educate patient on completing the full course of antibiotics and follow-up appointments.
Patient and family educated on recognizing signs of worsening infection.
Continue to monitor for any signs of complications or adverse reactions to medications.
Patient's condition to be reassessed in 24 hours for any adjustments in care plan.
Ensure proper hygiene and infection control measures to prevent further infections.