NURSING PROCESS

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Mr. X got admitted with fever for 3 days. List down the possible nursing diagnosis and draw a nursing process in detail for Mr. X .

POSSIBLE NURSING DIAGNOSIS

- Hyperthermia related to infection.
- Acute pain (head ache) related to increased body temperature.
- Imbalanced nutrition less than body requirement related to loss of appetite.
- Fluid volume deficit related to excessive diaphoresis.
- Activity intolerance related to high body temperature.

- Nausea related to indigestion and changes in taste perception.
- Impaired comfort related to excessive fatigue .
- Anxiety related to treatment and recovery process.
- Sleep deprivation related to hospitalization and discomfort.
- Knowledge deficit regarding care of fever.
- Risk for impaired skin integrity related to diaphoresis.

S . No	Assessment	Nursing diagnosis	Goal	Intervention	Rationale	Expected outcome
1	Subjective data: The patient may complains of fever Objective data: Mr. X is having increased body temperature 101 º F for 3 days.	Hyperthermia related to infection.	Mr.X's body temperature will be reduced with in 2 hours	•Monitor the degree and pattern of temperature of Mr.X. •Observe for chills or diaphoresis. •Encourage to drink adequate oral fluids. •Provide comfortable environment such as provide extra pillow & bedlinen,adequate ventilation. •Apply cold application. •Administer antipyretics as per doctor's advice.	•It provides baseline data •It helps to initiate required action. •It maintains normal hydration . •It maintains the body temperature within normal limit. •It reduces the high body temperature. •It decreases the high body temperature.	Mr.X's body temperature maintainerated at 98.6º F Client's skin looks hydrated.

S.No	Assessment	Nursing diagnosis	Goal	Intervention	Rationale	Expected outcome
2	subjective data: Mr.X may complaints of head ache. Objective data: Mr.X may have head ache.	Acute pain (head ache) related to increased body temperature.	Mr.X's pain will be relieved within 1hour	•Assess the level and nature of pain. •Apply hot fomentation. •Advice to drink warm fluid . •Encourage the client to do meditation. •Provide comfort measures to take rest. •Reduce unnecessary environmental stimuli. •Provide diversional therapy. •Provide Psychological support. •Administer analgesics as per the doctor's order.	•It provides baseline data. •It reduces the level of pain. •It inhibits the pain level. •It gives relaxation to body and mind. •It improves comfort of the client. •It decreases the strain of mind and body. •It reduces pain. •It gives comfort. •It relieves pain.	Mr.X relieved from head ache. Client looks comfort.

S . No	Assessment	Nursing diagnosis	Goal	Intervention	Rationale	Expected outcome
3	subjective Data: Mr. X may complains of loss of appetite. Objective Data: Mr. X may have loss of weight.	Imbalanced nutrition less than body requirement related to loss of appetite.	Mr.X's nutritional status will be improved with in 4 hours.	•Assess the nutritional status of the client. •Advice to take small and frequent feeds. •Encourage to eat soft diet. •Provide clean environment •Assess likes and dislikes of client. •Arrange for well balanced diet.	•It provides baseline data. •It improves nutritional status. •It helps for easy digestion. •It motivates to eat comfortably. •It guides to make diet plan. •It improves nutritional status.	Mr.X 's nutritional status is improved.

S . No	Assessment	Nursing diagnosis	Goal	Intervention	Rationale	Expected outcome
4	subjective Data: Mr. X may verbalize weakness, dry mouth Objective Data: Mr. X may have excessive sweating.	Fluid volume deficit related to excessive diaphoresis	Mr.X ‘s fluid volume will be improved within 4 hours	•Assess the fluid status of the client. •Maintain intake and output Chart. •Monitor blood pressure and heart rate . •Palpate peripheral pulses. •Review of dry mucous membranes, poor skin turgor and refined taste. •Encourage to drink more oral fluids about 3 litres per day. •Administer I.V fluid as per doctor’s order.	•It provides baseline data. •It helps to check cumulative imbalance. •It indicates any changes in fluid volume. •It helps to monitor fluid volume. •It guides to initiate immediate action. •It improves fluid volume status. •It improves fluid volume status.	Mr. X ‘s fluid volume is maintained within normal limits. His mucous membranes looks hydrated. Skin turgor is good.

S . No	Assessment	Nursing diagnosis	Goal	Intervention	Rationale	Expected outcome
5	subjective Data: Mr. X may verbalize weakness Objective data: Mr.X is not perfoming his own activities.	Activity intolerance related to high body temperature	Mr.X ‘s physical activities will be improve	•Assess the level of physical activity. •Provide comfort bed and environment. •Encourage to carryout simple tasks. •Advice to sleep on time and to take enough rest. •Apply cold compress. •Encourage to do exercises. •Administer medications as per doctor’s order.	•It provides baseline data. • It improves comfort. •It prevents activity intolerance. •It helps to improve physical activity. •It reduces high body temperature. •It relieves muscle regidity. •It promotes recovery .	Mr.X is performed his daily activities.