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Fever assessment and comfort Comfort & daily function

Nursing Foundation | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

32-year-old man with an acute febrile illness under investigation. Care stage: During supported recovery and essential daily activity.

Medical history: The current febrile illness developed recently with reduced appetite. No chronic immune-suppressing illness is reported in the fictional interview. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Chills, headache, poor appetite and feeling hot.

Objective findings and required checks: Raised temperature with reduced intake; full observations and infection assessment are required.

Physical examination and investigations: Record temperature site, full observations, hydration, exposure history and ordered blood or urine tests.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Fever assessment and comfort: Inflammatory mediators alter temperature regulation; the underlying cause determines risk.

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Medical / surgical management

Assess deterioration, support comfort and hydration within the plan, and obtain indicated samples.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Paracetamol	Prescribed relief of fever-related discomfort	Check combined products, liver risk and effect
prescribed antimicrobial	Treat an identified or suspected bacterial cause when indicated	Check allergy, specimens and response.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Chills, headache, poor appetite and feeling hot. Raised temperature with reduced intake; full observations and infection assessment are required. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize raised temperature increasing discomfort and fluid needs; insufficient fluid replacement for current losses; emotional distress affecting participation in care; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Assess deterioration, support comfort and hydration within the plan, and obtain indicated samples. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

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Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about chills, headache, intake and illness onset. Assess: Record temperature site, trend, hydration and other observations.	Raised temperature increasing discomfort and fluid needs. Possible factors: an inflammatory or infectious process. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Temperature-related discomfort improves and clinical deterioration is detected promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Explains monitoring, hydration instructions and warning signs for review.	1. Trend temperature together with circulation, breathing and mental state. Rationale: Temperature alone does not describe illness severity. 2. Provide comfortable clothing and fluids when permitted; avoid extreme cooling. Rationale: Supportive care reduces discomfort without provoking unnecessary stress. 3. Administer prescribed treatment and obtain ordered specimens using correct technique. Rationale: Cause-directed management and reliable samples support recovery. 4. Assess deterioration, support comfort and hydration within the plan, and obtain indicated samples. Rationale: Inflammatory mediators alter temperature regulation; the underlying cause determines risk. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: During the next agreed care or activity session:	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain monitoring, appropriate fluids, medicine instructions and when to return for review. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain monitoring, appropriate fluids, medicine instructions and when to return for review.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Confusion, breathing difficulty, non-blanching rash, shock or rapidly worsening condition needs urgent help.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Inflammatory mediators alter temperature regulation; the underlying cause determines risk.

- Priority concerns: Raised temperature increasing discomfort and fluid needs; Insufficient fluid replacement for current losses; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Confusion, breathing difficulty, non-blanching rash, shock or rapidly worsening condition needs urgent help.

- Explain monitoring, appropriate fluids, medicine instructions and when to return for review.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
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