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# Emotional distress affecting participation in care Fever assessment and comfort

Nursing Foundation | Focused diagnosis-based template

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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.

## 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.

## Medical / surgical management

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

## Illustrative drug and treatment study



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| 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.



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# Focused nursing-problem template

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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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 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: At the next patient-specific reassessment: 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. 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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## Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____



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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: Emotional distress affecting participation in care.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?**

## References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/



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