

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
SUBJECTIVE: "Waing gana dumedang anak ko, parang mainit sya at matamay" (<i>is difficult to feed my baby, she feels warm to touch and not very active</i>) as verbalized by the mother. OBJECTIVE: - Increased body temperature. - Flushed skin. - Increased respiratory rate. - V/S taken as follows: T: 37.7 P: 130 R: 45	Risk for infection related to compromised immune system.	Sepsis is a clinical term used to describe symptomatic bacteremia, with or without organ dysfunction. Sustained bacteremia, in contrast to transient bacteremia, may result in a sustained febrile response that may be associated with organ dysfunction. Septicemia refers to the active multiplication of bacteria in the bloodstream that results in an overwhelming infection.	After 8 hours of nursing interventions, the patient will achieve timely healing and free from further infection.	INDEPENDENT: - Provide isolation and monitor visitors as indicated. - Wash hands before or after each care activity, even gloves are used. - Limit use of invasive devices or procedure as possible. - Inspect wounds or site of invasive devices, paying particular attention to parenteral lines.	- Body substance isolation (BSI) should be used for all infectious patients. Reverse isolation/restriction of visitors may be needed to protect the immunosuppressed patient. - Reduces risk of cross contamination because gloves may have noticeable defects, get torn or damaged during use. - Prevents spread of infection via airborne droplets. - May provide clue to portal entry, type of primary infecting organisms, as well as early identification secondary infection.	After 8 hours of nursing interventions, the patient was able to achieve timely healing and free from further infection.

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