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Pulmonary tuberculosis Comfort & daily function

Adult Health Nursing | 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

37-year-old man with confirmed pulmonary TB. Care stage: During supported recovery and essential daily activity.

Medical history: Persistent cough and weight loss led to microbiological confirmation of pulmonary TB. The patient has begun the approved program-based treatment pathway. 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: Persistent cough, weight loss, night sweats and treatment concerns.

Objective findings and required checks: Reduced weight and respiratory symptoms; transmission precautions are in place.

Physical examination and investigations: Review approved microbiological testing, imaging, treatment susceptibility information and baseline safety tests.

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

Clinical focus and pathophysiology

Pulmonary tuberculosis: Mycobacterial infection causes pulmonary inflammation and may spread through airborne particles.

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Medical / surgical management

Follow national TB and infection-control pathways; support treatment access, nutrition and confidential contact-related care.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed multidrug anti-TB regimen	Treat confirmed TB according to the national program	Monitor adherence, interactions and drug-specific adverse effects
no single-drug self-treatment	Avoid resistance-promoting treatment errors	Refer all changes to the treating team.

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

Nursing process - ADPIE

Assessment

Persistent cough, weight loss, night sweats and treatment concerns. Reduced weight and respiratory symptoms; transmission precautions are in place. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize difficulty clearing respiratory secretions; nutritional intake below current needs; difficulty sustaining the agreed treatment plan; 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

Follow national TB and infection-control pathways; support treatment access, nutrition and confidential contact-related care. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

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

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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: Report sputum, cough effectiveness and chest discomfort. Assess: Observe airway sounds, cough, secretions and ability to speak.	Difficulty clearing respiratory secretions. Possible factors: retained secretions and reduced cough effectiveness. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Airway remains patent and the patient demonstrates a more effective cough. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed secretion-management technique before discharge.	1. Assess cough, breath sounds and secretion changes. Rationale: Changes can indicate obstruction or worsening infection. 2. Support a comfortable upright position and coached coughing when appropriate. Rationale: Position and an effective cough can help secretion clearance. 3. Provide prescribed inhaled treatment or suction only when indicated and within competence. Rationale: Targeted therapy supports airway clearance while limiting procedural harm. 4. Follow national TB and infection-control pathways; support treatment access, nutrition and confidential contact-related care. Rationale: Mycobacterial infection causes pulmonary inflammation and may spread through airborne particles. 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 usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings.	Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements.	1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support.	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 about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	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 understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	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.	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. Teach treatment completion, cough etiquette, ventilation, program support and follow-up without stigma. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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

Teach treatment completion, cough etiquette, ventilation, program support and follow-up without stigma.

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

Hemoptysis with instability, severe breathlessness, jaundice or major adverse reactions need prompt review.

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

- Mycobacterial infection causes pulmonary inflammation and may spread through airborne particles.

- Priority concerns: Difficulty clearing respiratory secretions; Nutritional intake below current needs; Difficulty sustaining the agreed treatment plan; Learning needs about the condition and care plan.

- Hemoptysis with instability, severe breathlessness, jaundice or major adverse reactions need prompt review.

- Teach treatment completion, cough etiquette, ventilation, program support and follow-up without stigma.

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

References

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